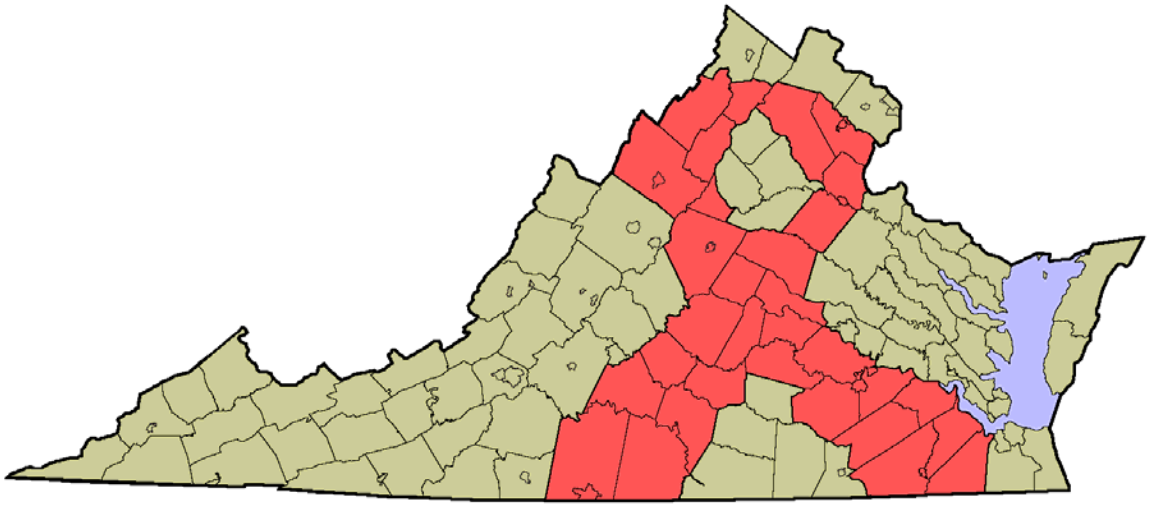
Virginia Department of Health
Division of Disease Prevention

Statewide Comprehensive Plan for HIV Services

2005



VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

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Letters of Concurrence

DIVISION OF HIV/STD
COMMONWEALTH of VIRGINIA
2006 JAN 20 P 2:15
THREE RIVERS HEALTH DISTRICT

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P. O. Box 663
Gloucester, VA 23061
(804) 693-2445, Environmental 693-6130
FAX: (804) 693-1398

District Office
P. O. BOX 415
SALUDA, VIRGINIA 23149
FAX 804-758-4828
TELEPHONE 804-758-2381

January 19, 2006

To whom it may concern:

As the chair of the Ryan White Subcommittee of the Virginia HIV Community Planning Committee, I concur with the content and strategies proposed in the 2005 Statewide Comprehensive Plan (SCP).

This three year plan for HIV health care services in the Commonwealth of Virginia incorporates the voices of many individuals, including people living with HIV/AIDS, community-based service providers, as well as representatives from governmental agencies. Input gathered at five public hearings across the state and current needs collected from regional needs assessments are incorporated into the plan.

To monitor progress in meeting long- and short-term goals and objectives, the strategies of quality management and training, contract monitoring, and community feedback will be employed. I encourage all agencies and service providers in the Commonwealth of Virginia to use the information in this plan as a guide to improve HIV health care services.

Sincerely,

Richard A. Hall
VDH Health Counselor and
Chair of Ryan White Subcommittee --
VA HIV CPC

COMMONWEALTH of VIRGINIA

Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

January 31, 2006

Casey W. Riley
Director, Division of Disease Prevention
109 Governor Street, Rm. 326
Richmond, Virginia 23219
Add address

Dear Mr. Riley:

As the chair of the AIDS Drug Assistance Program (ADAP) Advisory Committee, I concur with the content and strategies proposed in the 2005 Statewide Comprehensive Plan (SCP).

This three year plan for HIV health care services in the Commonwealth of Virginia incorporates the voices of many individuals, including people living with HIV/AIDS, community-based service providers, as well as representatives from governmental agencies. Input gathered at five public hearings across the state and current needs collected from regional needs assessments are incorporated into the plan.

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Sincerely,

Grayson B. Miller, Jr., MD
Chair, ADAP Advisory Committee

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

PATRICK W. FINNERTY
DIRECTOR

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

January 19, 2006

To whom it may concern:

As a member of the Statewide Comprehensive Plan (SCP) Advisory Committee, I concur with the content and strategies proposed in the 2005 SCP. These strategies reflected the priorities expressed by the SCP Advisory Committee during its monthly meetings from July to November of 2005.

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Sincerely,

Cindy Olson
Senior Policy Analyst

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

JAMES S. REINHARD, M.D.
COMMISSIONER

Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dmhmrsas.state.va.us

January 19, 2006

To whom it may concern:

As a member of the Statewide Comprehensive Plan (SCP) Advisory Committee, I concur with the content and strategies proposed in the 2005 SCP. These strategies reflected the priorities expressed by the SCP Advisory Committee during its monthly meetings from July to November of 2005.

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Sincerely,

Denise S.C. Clayborn
HIV Human Services Consultant,
Office of Substance Abuse Services

COMMONWEALTH of VIRGINIA

GENE M. JOHNSON
DIRECTOR

Department of Corrections

P. O. BOX 26963
RICHMOND, VIRGINIA 23261
(804) 674-3000

January 2006

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Sincerely,

Opal Breeden

COMMONWEALTH of VIRGINIA

DEPARTMENT OF
HOUSING AND COMMUNITY DEVELOPMENT

Tim Kaine
Governor

Patrick O. Gottschalk
Secretary of
Commerce and Trade

William C. Shelton
Director

January 26, 2006

Ben Alonso, HIV Health Care Planner
109 Governor Street
P.O. Box 2448, Room 326
Richmond, VA 23218

Dear Mr. Alonso:

As a member of the Statewide Comprehensive Plan (SCP) Advisory Committee, I concur with the content and strategies proposed in the 2005 SCP. These strategies reflected the priorities expressed by the SCP Advisory Committee during its monthly meetings from July to November of 2005.

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If you have any questions, please feel free to contact me at (804) 225-3115.

Sincerely,

Harry W. Miles
Regional Housing
Program Administrator

Partners for Better Communities
www.dhcd.virginia.gov
The Jackson Center . 501 North Second Street . Richmond, Virginia 23219-1321 . Phone (804) 371-7000 . Fax (804) 371-7090 . TDD (804) 371-7089

VCU

Virginia Commonwealth University

MCV Campus

January 19, 2006

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RECEIVED

R.A.C.
Community Advisory Board

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P.O. Box 980049
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804 828-9458
Fax: 804 828-0570
TDD: 1-800-828-1120

To whom it may concern:

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Sincerely,

George Kelly

George P. Kelly, BS
Chairman
RAC CAB

INOVA JUNIPER PROGRAM

8001 Forbes Place, Suite 200
Springfield, Virginia 22151

Tel 703-321-2600
800-828-4927
Fax 703-321-2603

January 2006

To Whom It May Concern:

As a member of the Statewide Comprehensive Plan (SCP) Advisory Committee, I concur with the content and strategies proposed in the 2005 SCP. These strategies reflected the priorities expressed by the SCP Advisory Committee during its monthly meeting from July to November of 2005.

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Sincerely,

Peggy Beckman

Peggy Beckman, MSN, CANP
Director
Inova Juniper Program, HIV Clinical & Educational Services
(703) 321-2621
Peggy.Beckman@Inova.com

City of Norfolk
Greater Hampton Roads HIV Health Services Planning Council
Ryan White Title I Program

January 27, 2006

To whom it may concern:

As a member of the Virginia Statewide Comprehensive Plan (SCP) Advisory Committee, I concur with the content and strategies proposed in the 2005 SCP. These strategies reflected the priorities expressed by the SCP Advisory Committee during its monthly meetings from July to November of 2005.

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Sincerely,

Kenyette T. Barnes-Harper, EdM
Health Planner, Norfolk EMA-Ryan White Title I

500 E. Plume Street, Suite 205 • Norfolk, VA 23510
(757) 441-1403 • Fax (757) 441-1108
Ensuring the effective and efficient delivery of medical and support services to PLWH/A in Hampton Roads

COUNCIL of COMMUNITY SERVICES
Gateway to information and planning.

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P.O. Box 598, Roanoke, Virginia 24004
Phone: 540.985.0131
Fax: 540.982.2935
Website: www.councilofcommunityservices.org
Email: info@councilofcommunityservices.org

January 19, 2006

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Sincerely,

Robert F. Morrow
Director of Care Services
Health Outreach and Wellness
Council of Community Services

AIDS/HIV SERVICES GROUP
963 2nd St. S.E.
Charlottesville VA 22902
434-979-7714
434-979-8734 fax
www.aidsservices.org

January 20, 2006

To whom it may concern:

As a member of the Statewide Comprehensive Plan (SCP) Advisory Committee, I concur with the content and strategies proposed in the 2005 SCP. These strategies reflected the priorities expressed by the SCP Advisory Committee during its monthly meetings from July to November of 2005.

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Sincerely,

Michael Mallett
Grants Manager

January 2006

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Sincerely,

Ruth Royster

January 27, 2006

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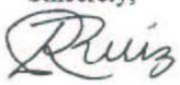

Tony Ruiz

January 2006

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Sincerely,

Michael McIntyre
SCP Advisory Board Member

Contributors

Statewide Comprehensive Plan Advisory Committee

Kenyette Barnes-Harper	Norfolk Eligible Metropolitan Area Title I Planning Council
Peggy Beckman	Inova Juniper Program
Opal Bristow	Department of Corrections (DOC)
Denise Clayborn	Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)
George Kelly	Richmond AIDS Consortium
Michael Mallett	AIDS Service Group
Michael McIntyre	Appalachian Assistance Coalition
Harry Miles	Department of Housing and Community Development (DHCD)
Robert Morrow	Council of Community Services
Cindy Olson	Department of Medical Assistance Services (DMAS)
Ruth Royster	Children's AIDS Network Designed for Interfaith Involvement (CANDII)
Tony Ruiz	DC Title I Eligible Metropolitan Area Planning Council

Virginia Department of Health
Division of Disease Prevention (hiv, std, tb, Rx)

Casey Riley	Director
Kathryn Hafford	Deputy Director
Diana Jordan	Director, HIV Health Care Services Unit
Elaine Martin	Director, Community Services Unit
Greg Dennis	Data Manager
Chris Delcher	Epidemiologist
Ben Alonso	HIV Health Care Planner
Ami Gandhi	HIV Prevention Community Planner
Michelle Baker	Contract Monitor
Safere Diawara	Contract Monitor
Faye Bates	ADAP Coordinator
Rae Price	Quality Management Nurse

Introduction

The purpose of the Statewide Comprehensive Plan (SCP) is to establish service and resource allocation priorities, goals and objectives for the Title II-funded services of the Ryan White Comprehensive AIDS Resources Emergency Act (RWCA). The plan also maps out maintenance and improvement of a system of care that is responsive to the changing epidemic and the unmet health care needs of those currently not in care.

Representatives from all RWCA Titles, Consortia, Ryan White (RW) Subcommittee of the Virginia HIV Community Planning Committee (HCPC), Housing Opportunities for People with AIDS (HOPWA), Department of Medical Assistance Services (DMAS), Department of Corrections (DOC), Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and Virginia Department of Health (VDH) met monthly from July to November 2005 to develop this plan. Consumers were a very important part of this process. The process utilized the Statewide Coordinated Statement of Need (SCSN), the work of the RW Subcommittee of the HCPC, findings from five public hearings held across the state and other most recent statewide and regional HIV needs assessments to identify gaps in services and barriers to care. Epidemiological data was used to identify trends in the HIV/AIDS epidemic and needs generated by changes in the epidemic.

Executive Summary

The shared values of access, equity, excellence, collaboration, and empowerment are principles that help guide the continuum of care in the Commonwealth of Virginia. Based on these values and needs identified across Virginia, the following broad long-term goals have been established by the SCP Advisory Committee to guide priority setting:

- Provide equitable access to services for all people living with HIV/AIDS (PLWH/A) – regardless of age, race, ethnicity, gender, sexual orientation, religion, socioeconomic status, residence, language and physical appearance.
- Increase collaboration between care and prevention to increase healthy behaviors among HIV-positive individuals and reduce the transmission rate of new HIV infections.
- Ensure that HIV-positive individuals receive optimum health care and support services that extend and improve quality of life.

To improve quality of care and monitor progress in meeting long- and short-term goals and objectives, the strategies of quality management and training, contract monitoring, and community feedback will be employed. The goals and the resulting program initiatives included in this plan were created under the premise of continued current levels of federal, state, and local funding. If significant changes in resources occur, alterations will need to be made to the overall plan, goals and objectives.

Section 1. Where are we now: What is our current system of care?

Description of Virginia[1]

Virginia is the 35th largest state in the United States, covering 42,774 square miles. It is roughly triangular in shape and has a maximum extent from east to west of 469 miles and a maximum from north to south of 201 miles. Virginia is bounded on the east by the Atlantic Ocean, on the north and east by Maryland and the District of Columbia, on the west by West Virginia and Kentucky, and on the south by Tennessee and North Carolina.

According to the United States Census 2000, Virginia's population was 7,078,515, ranking it 12th among the states. In 2000, 73 percent of the population lived in urban areas, compared to 47 percent in 1950. Virginia has three major metropolitan areas in its metropolitan corridor: Northern Virginia, Richmond-Petersburg, and Hampton Roads. Virginia's other metropolitan areas include Roanoke, Lynchburg, Charlottesville, Danville, and Bristol. Virginia's population density in 2004 was 188 per square mile.

At the time of Census 2000, Whites constituted 72.3 percent of the population, African-Americans 19.6 percent, Asians 3.7 percent, Native Americans 0.3 percent, Native Hawaiians and other Pacific Islanders 0.1 percent, and those of mixed heritage or not reporting race 4 percent. Hispanics, who may be of any race, were 4.7 percent of Virginia's population. Virginia's three large metropolitan areas are extremely ethnically diverse. The Norfolk area, in particular, has one of the nation's largest Filipino communities, and northern Virginia has the largest Vietnamese community on the East Coast. Northern Virginia is also home to large communities of Hispanics, especially from Central America, as well as a large Korean community.

Epidemiological Profile

Acquired Immunodeficiency Syndrome (AIDS) was first reported in the Commonwealth of Virginia in 1982. In the late-eighties to the mid-nineties, the confluence of two key events had a significant impact on the reports of those infected with Human Immunodeficiency Virus (HIV) and AIDS (See Figure 1 and Table 1). First, HIV became reportable in Virginia in 1989, which was followed by an expansion of the AIDS case definition by the Centers for Disease Control and Prevention (CDC) in 1993. Together, these events led to significant increases in the number of newly reported cases of HIV/AIDS in Virginia. Second, the advent of new HIV treatment strategies resulted in an overall decline in the number of new AIDS cases being diagnosed.

As of mid-2005, it is estimated that 27,800 Virginians are infected and living with HIV. Approximately 6,000 to 8,000 of those individuals may not know they are infected. According to CDC's estimated HIV/AIDS prevalence and incidence data, newly-diagnosed AIDS cases increased from 670 to 734 (9.6%) from 2003 to 2004. Cases

[1] "Virginia (state)," Microsoft® Encarta® Online Encyclopedia 2005 http://encarta.msn.com © 1997-2005 Microsoft Corporation. All Rights Reserved.

among non-Hispanic African-Americans increased by 21% (422 to 509) whereas cases among the other races either decreased or stayed the same. Cases among 13-19 year olds increased significantly from 1 in 2003 to 9 in 2004. The overall increase was also driven by cases identified as men who have sex with men (MSM) and injection drug users (IDU) with IDUs being disproportionately impacted. Furthermore, heterosexually identified cases decreased from 2003 to 2004. The trend seen in these three risk categories represents a reversal of the trends seen in the previous period. See Table 2.

Of the 7,916 cases of persons living with AIDS through December 2004, 46% were over 45 years old and 26% of persons were exposed through heterosexual contact. Persons living with AIDS were predominantly MSM (46%), non-Hispanic African-American (59%) and male (77%). See Table 3.

There were 9,154 cases of persons with HIV (not AIDS) as of December 2004. One third of the cases were female, 65% were non-Hispanic African-American and 34% were over the age of 44. Virginia's estimated prevalence of HIV infection, based on the 9,154 cases of persons with HIV (not AIDS) and the 7,916 cases of AIDS is 17,070. See Table 4.

A total of 1,004 new AIDS cases were reported in Virginia between 2003 and 2004. The number of new AIDS cases remained steady from 505 in 2003 to 499 in 2004. At the end of 2004, there were an estimated 7,515 people living with AIDS. This represents an increase of 6.5% since 2003, when an estimated 7,060 people were living with AIDS. At the end of 2004, there were an estimated 8,975 people living with HIV (not AIDS). This represents an increase of 9.3% since 2003, when an estimated 8,207 people were living with HIV (not AIDS).

These epidemiological trends of increasing HIV prevalence have greatly impacted the ability of the current continuum of care to provide antiretroviral therapy and health care services. As more people are living with HIV/AIDS, the cost to implement and maintain essential programs continues to increase. At the same time, federal funding for prevention, surveillance, and care has not been increased to meet the need and recent federal grant funding for HIV has often been decreased. Inability to actively monitor cases, provide prevention education, and ensure a safety net of health care services, will compound an already challenging situation.

Please refer to Appendix B for the complete report "2003 Epidemiology Profile: HIV and AIDS in Virginia."

Figure 1. Virginia faces a growing need for health care services as the population of those living with HIV/AIDS increases.

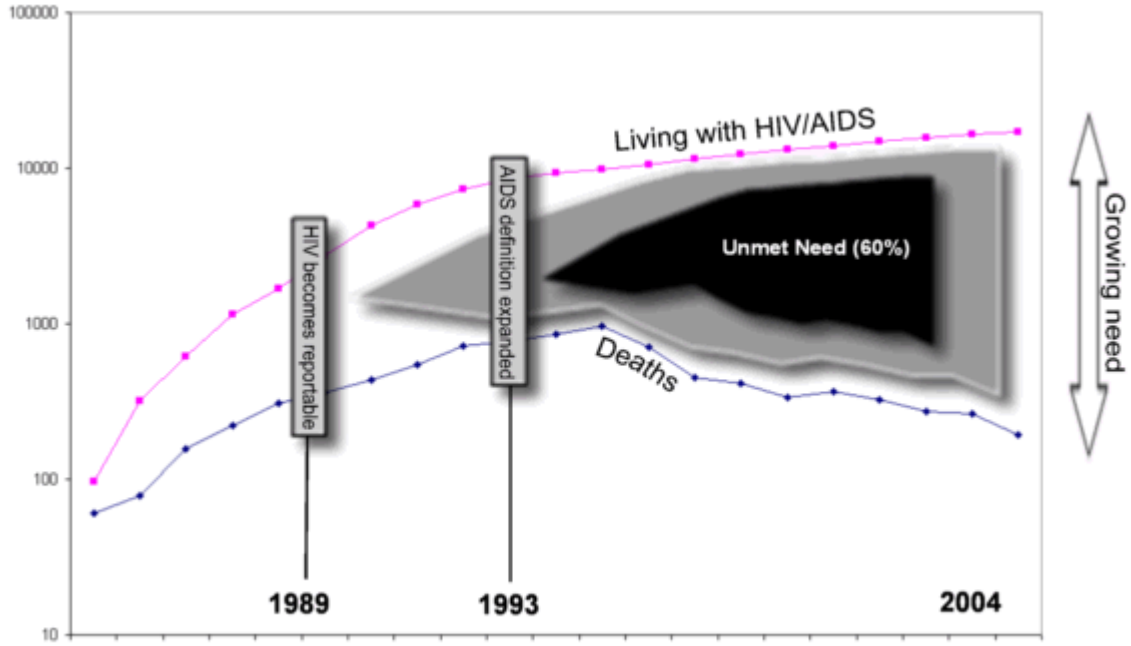


Table 1. Reported Cases of HIV/AIDS in Virginia by Year

1982	5
1983	21
1984	42
1985	102
1986	166
1987	264
1988	368
1989	627
1990	1713
1991	2176
1992	1898
1993	2477
1994	1747
1995	1941
1996	1570
1997	1555
1998	1295
1999	1323
2000	1242
2001	1391
2002	1446
2003	1191
2004	1288

Table 2. Virginia AIDS cases (incidence) by exposure.

Exposure	2003	%	2004	%
Men who have sex with men (MSM)	259	38.7	288	39.2
Injection drug use (IDU)	112	16.8	145	19.8
MSM & IDU	19	2.9	26	3.5
Heterosexual contact	273	40.7	263	35.9
Adult other	4	0.5	10	1.3
Adult undetermined	1	0.2	3	0.40
Mother with HIV infection	1	0.2	0	0

Table 3. Virginia AIDS cases (prevalence) by exposure, race and age as of 12/2004.

Exposure	Total	%	Race	Total	%	Age	Total	%
Men who have sex with men (MSM)	3671	46.4	Non Hispanic White	2725	34.4	0-12 yrs	45	0.6
Injection drug use (IDU)	1493	18.9	Non Hispanic African-American	4656	58.8	13-19 yrs	52	0.7
MSM & IDU	416	5.25	Hispanic	418	5.3	20-44 yrs	4204	53.1
Heterosexual contact	2095	26.5	Asian	72	0.9	45+ yrs	3615	45.7
Older perinatal	2	0.03	Indian	8	0.1			
Adult other	126	1.6	Multi-race	33	0.4			
Adult undetermined	21	0.3	Unknown	5	0.1			
Mother with HIV infection	90	1.1						
Pediatric other	3	0.04						

Table 4. Virginia HIV not AIDS cases (prevalence) by exposure, race and age as of 12/2004.

Exposure	Total	%	Race	Total	%	Age	Total	%
Men who have sex with men (MSM)	3977	43.5	Non Hispanic White	2634	28.8	0-12 yrs	49	0.53
Injection drug use (IDU)	1478	16.2	Non Hispanic African-American	5917	64.6	13-19 yrs	82	0.90
MSM & IDU	360	3.9	Hispanic	460	5.0	20-44 yrs	5943	64.9
Heterosexual contact	3162	34.5	Asian	70	0.77	45+ yrs	3080	33.6
Adult other	90	1.0	American Indian	9	0.10			
Adult undetermined	2	0.02	Multi-race	9	0.10			
Mother with HIV infection	73	0.80	Unknown	54	0.59			
Pediatric other	8	0.09						
Pediatric undetermined	3	0.04						

Description of the History of Virginia's Response to the Epidemic

The first case of AIDS was reported in Virginia in 1982. HIV, the virus that can lead to AIDS, became reportable in 1989. As of mid-2005, it is estimated that 27,800 Virginians are infected and living with HIV. Approximately 6,000 to 8,000 of those individuals may not know they are infected. The state response to the epidemic has been a multi-agency effort including prevention and health care services from VDH and Medicaid health insurance administered by DMAS.

VDH began its HIV prevention services in 1985 with the establishment of an AIDS hotline. Funding for health education followed in 1986 with the establishment of five regional AIDS service organizations through a combination of state and federal funds. Virginia was the first state to offer routine HIV testing in STD clinics in 1986. Prevention services currently supported by federal and state funding include: counseling, testing, and referral services for individuals with HIV and their partners; health education/risk reduction (prevention interventions); public information including public information campaigns and hotline services; capacity building for health department staff and community-based organizations; community planning; and program evaluation.

When the AIDS epidemic in Virginia was first detected in the early 1980s, few resources were available to respond to the emerging crisis, and mortality rates were extremely high for persons diagnosed with AIDS. After the development of life-saving antiretroviral medications, treatment beyond hospice care became available. In 1987, VDH first received federal HIV funds for the purpose of purchasing zidovudine, the only antiretroviral available at that time for HIV treatment. In 1990, the Virginia General Assembly first appropriated state funding for HIV medication.

Today, through a combination of state and federal funds, the AIDS Drug Assistance Program (ADAP) in Virginia provides 71 life-saving medications, including 27 antiretrovirals, to well over 3,000 low-income clients annually (See Figure 2). To comply with the Health Resources and Services Administration's (HRSA) requirement that ADAP be used as the payer of last resort, all participants are carefully screened to ensure eligibility for this program. Participants must be both ineligible for Medicaid and have an annual family income no greater than 300% of the federal poverty level (FPL). In Northern Virginia, the limit is 333% FPL to account for the higher cost of living. Clients need to provide proof of income and lack of other insurance when applying for ADAP and annually when eligibility is recertified.

Local health departments (LHDs) play a key role in delivering ADAP services by providing both client eligibility determination and access to medications. By utilizing LHDs to perform these ADAP functions, Virginia has set up an efficient service delivery model with a very low administrative cost.

ADAP's current challenges are significant and include increased demands on the program and uncertain funding prospects in the future. Although HIV infection rates

have decreased, new ADAP enrollments have remained stable while discharges have slowed, resulting in longer enrollment durations and net program growth (See Table 5).

In addition to ADAP, the Division of Disease Prevention of VDH has administered RWCA funds since 1991 through five regional consortia. Average duration of service utilization for clients receiving consortia-based services in Virginia increased 36 percent in the last two years (See Table 6). The impact of increased demand has been exacerbated by a decrease in funding. Virginia's current year Title II base award was cut 6.5 percent from the previous year's award. With current funding, access to primary medical care is inadequate to serve all individuals eligible for RWCA services. (See section entitled "Profile of RWCA-Funded Providers" for a more complete description of the RWCA-funded programs.)

In addition to RWCA-funded programs, many persons living with HIV/AIDS in Virginia receive their medical care through Medicaid. Through the Medicaid State Plan or the AIDS Waiver, Virginia provided services to 2,860 individuals with HIV/AIDS in state fiscal years 2003 through 2005. Individuals with HIV/AIDS may qualify for Medicaid if they meet the qualifications of a particular eligibility group, in addition to the income and resource requirements. Persons that do not belong to an eligibility group may still receive full Medicaid benefits if they are determined to be disabled. In Virginia, an HIV or AIDS diagnosis does not automatically qualify a person as disabled; a person's medical condition must have deteriorated enough to qualify for a Social Security disability program.

For individuals who qualify as categorically needy, Medicaid provides inpatient and outpatient hospital services, physician and laboratory services, and certain forms of long-term care. In addition to these mandatory services, Virginia also provides prescription drug coverage for eligible individuals.

For persons with more advanced stages of HIV/AIDS, Medicaid offers waiver programs which provide home-based services for individuals who may otherwise have been institutionalized in an inpatient hospital or nursing facility. To receive waiver services, an individual must meet alternate institutional guidelines in addition to meeting Medicaid eligibility requirements. Unique to the AIDS Waiver, individuals are allowed to retain a personal maintenance allowance three times greater than for other waivers in Virginia. The services available through the AIDS Waiver include case management, nutritional supplements, private duty nursing, personal care, and respite care.

In the third decade of the epidemic, HIV/AIDS continues to present significant challenges to Virginia's public health system. As more people are living with HIV/AIDS, the cost to implement and maintain essential programs continues to increase. At the same time, federal funding for prevention, surveillance, and care has not been increased to meet the need and recent federal grant funding for HIV has often been decreased. Inability to actively monitor cases, provide prevention education, and ensure a safety net of health care services, will compound an already challenging situation.

Figure 2. Number of Medications by Drug Class on ADAP Formulary

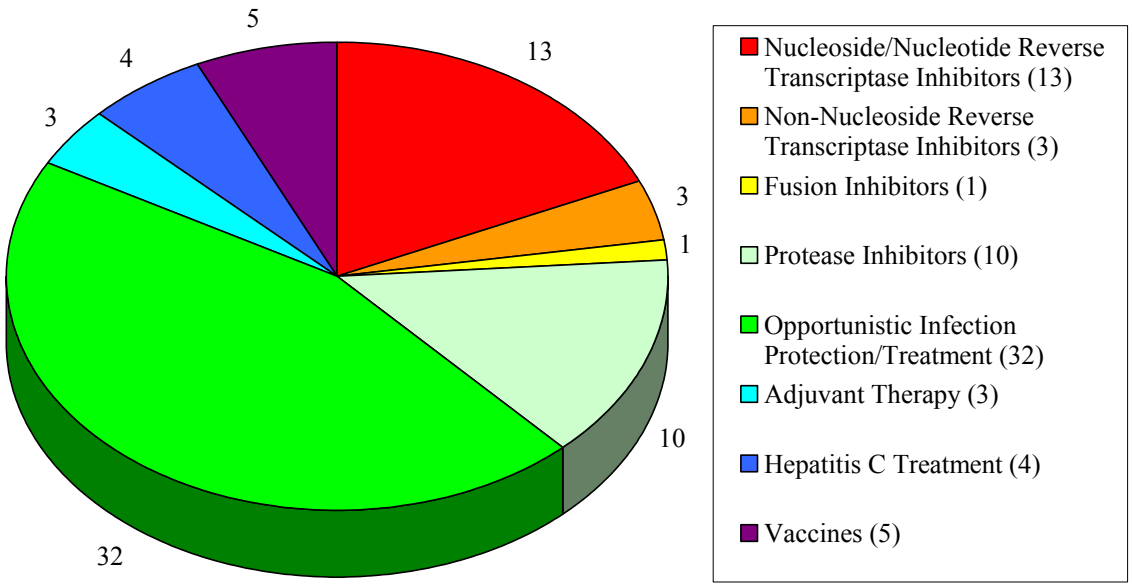


Table 5. ADAP Changes From 1999 Through September 2005

Calendar Year	Avg. persons per month	Avg. cost per person per month	Total Rx	Avg. Rx per month	Total Cost	Total Persons Served	Avg. Length of Enrollment (months)
1999	1137	$789	48165	4014	$10,828,681	2425	N/A
2000	1274	$809	53524	4460	$12,405,716	2731	16.4
2001	1439	$877	57859	4822	$15,161,608	2921	20.6
2002	1494	$944	58969	4914	$16,923,097	3006	26.1
2003	1588	$1,003	63624	5302	$19,158,533	3193	26.6
2004	1730	$1,066	71047	5921	$22,141,049	3411	32.4
2005 (thru Sept)	1760	$1,089	52868	5874	$17,270,315	3227	45.4

Table 6. Title II Consortia Changes From 2000 Through September 2005

Calendar Year	Avg. persons served per month	Total persons served per year	Avg. services per month	Total Services per year	Avg. Length of Enrollment (months)
2000	430	1327	1123	13390	N/A
2001	700	1872	2316	27506	9.60
2002	857	2481	3032	35929	13.50
2003	1098	2993	4312	50556	18.40
2004	1159	3533	4344	50800	21.10
2005 (thru Sept)	1130	2943	3549	31230	28.60

Assessment of Need

Regional Needs Assessments

In Virginia, regional needs assessments are conducted biannually, by the five consortia, to identify the issues and concerns of persons living with HIV/AIDS. These assessments provide the most current information on the needs, both perceived and actual, facing individuals in the state. The information contained in these reports is used by consortia to ensure effective and efficient planning, implementation, and evaluation of HIV health and social services in each region.

Needs assessments are typically conducted through the use of surveys, focus groups, or key informant interviews. In the current grant year in Southwest Virginia, for example, six-page surveys, containing both closed and open-ended questions were mailed directly to clients and distributed by case managers. For clients who chose to return the survey individually, self-addressed envelopes were provided. In Northern Virginia, eight focus groups were led and recorded by community volunteers. One half of the groups were led in focus group discussions on general topics related to HIV/AIDS, while the other half were led in discussions on a more housing-focused agenda. Each group also answered a few additional questions to gather information related to their specific needs and preferences related to HIV service programming.

In 2004, the Norfolk Title I Eligible Metropolitan Area (EMA) and the Title II Eastern Virginia HIV Care Consortium combined their needs assessments. Committee members and representatives from Title I and Title II developed four different surveys (consumer, front-line worker, provider and out-of-care). They also conducted focus groups and key informant interviews. According to the surveys, overall, consumers were satisfied with the services available. Most believed that they received referrals when needed. Focus group participants and key informant interviewees indicated that transportation, lack of cultural competency/sensitivity, homelessness/housing, and lack of providers are major barriers to care. With more than 70% of all HIV-related services located in Norfolk, there is a scarcity of providers in the rural and suburban areas in the rest of the region. According to provider surveys, it is believed that funding, lack of service providers, inadequate coordination of care services, reimbursement timelines, limited funding and consumers' non-adherence to treatment regimens are major barriers to providing quality HIV care.

In 2005, Norfolk Title I updated their needs assessment report by conducting focus groups and key informant interviews. Ten focus groups with a total of 40 participants were conducted, targeting MSM, substance abuse/intravenous drug users (SA/IDU), women of childbearing age, and transgender populations. The general needs found were transportation, housing/homelessness, and access to care issues, provider sensitivity, provider competency, and front-line staff issues. Also, key informant interviews were conducted with representatives from the following client populations: MSM, women, SA/IDU, transgender, and youth. The general needs identified included transportation, housing, cultural sensitivity, and client advocacy.

Because the biannual needs assessments are being conducted in the current grant year, the reports are still in development in several Title II regions. At the time of writing, only the results from two out of five regions were available. It is expected that all regions will have their final needs assessment reports completed in the near future. When all of the regional needs assessments from this year are completed, results will be compared with findings from previous assessments. From the two assessments that have been completed, the top needs appear to be consistent with findings from previous assessments. Some additional needs have also been identified, including substance abuse services, mental health services, and vision care.

The last compilation of the five regional assessments is from 2003. The eight top needs identified from the results of these compiled needs assessments were:

a. Dental services
b. Medication assistance
c. Transportation
d. Emergency financial assistance
e. Help obtaining government benefits
f. Food
g. Primary medical care
h. Case Management

Statewide Coordinated Statement of Need (SCSN)

The compiled needs assessments from 2003 were used as a framework to identify the cross-cutting issues discussed during the SCSN meeting held in 2004. In January of 2004, a steering committee made up of HIV-infected and affected individuals, providers, researchers, and advocates came together and diligently worked to develop an SCSN process that identified cross-cutting issues, developed strategies to address barriers and created broad goals to be used in the comprehensive planning process. The steering committee identified a theme of "Changing Times, Changing Lives", which marked a step towards the HIV community addressing the changing funding and policy issues affecting HIV care. On June 17 and 18, 2004, one hundred and seven attendees from the five Virginia health regions, seventeen facilitators and five VDH staff came together to provide input into the 2004 SCSN. As explained in greater detail in the SCSN document, the top cross-cutting issues were:

a. Inadequate funding
b. Need for improved provider training especially in the area of cultural competency
c. Need for improved integration of services with consistent care standards
d. Lack of support services such as housing and transportation
e. Need for more education for consumers, especially job training

The results of the SCSN were incorporated into the SCP by developing strategies to address the identified needs. For continuity, several members of the SCSN Steering

Committee were invited to participate in the SCP Advisory Committee as well. During the planning process, all members of the SCP Advisory Committee were given copies of the SCSN and the needs identified in it were summarized in a presentation. With the SCSN as a guide, the committee developed goals and strategies that address identified needs such as cultural competency training, empowering clients, and integrating support services.

Public Hearings

In October of 2005, VDH held five public hearings across the state to gain input into the planning process. There were a total of 75 attendees. This is a significant increase from only 16 attendees in 2004. In contrast with last year, the public hearings were held in conjunction with the Community Services Unit and the public hearings were held in all five regions of the state. VDH worked closely with regional consortia in planning the date, time, and location of each public hearing to make them most accessible for consumers.

The public hearings were publicized through various forms of communication. One month in advance, announcements were posted on the Commonwealth Calendar, an internet-based listing of state government meetings. Announcements also appeared on the VDH website and an electronic bulletin e-mail that was distributed to the HIV community. Fliers were created and distributed through lead agencies, consortia, and resource centers. Advertisements were placed in the legal notices section of local newspapers one week prior to each event. Following each public hearing, minutes were posted on the VDH website.

Among the attendees were persons living with HIV/AIDS from the general population and representatives from various agencies involved in HIV care or prevention. Representatives from all five consortia, Title II lead agencies and subcontractors, two Minority AIDS Initiatives (MAI), both Title I EMAs, three Title III grantees, both Title IV grantees, and two AIDS Education and Training Center (AETC) local performance sites were in attendance. Representatives from agencies not funded by RWCA, such as several local health departments, a prevention agency, and HOPWA also attended. With participation expanded from last year, a broader range of input was collected for the SCP.

Attendees were given a summarized outline of the goals included in the SCP and encouraged to provide comments or general feedback. For general medical care and support services, attendees stated the need for improved access to mental health and substance abuse services and an increase of dental and infectious disease specialists in rural areas. When polled about strategies to empower clients, attendees expressed a desire for increased peer advocacy and political advocacy. Attendees stated that more translated materials and improved transportation in rural areas were needed when asked how to eliminate barriers to care. As for the ways to improve provider competence, reducing the data requirements and increasing capacity building would be helpful for smaller agencies.

The HIV Prevention Community Planner, plus an additional member of the Community Services Unit, attended all five public hearings and gathered input related to prevention issues. Attendees stated that increased apathy and an increase in indigent clients were among the changes in the population and/or risk behavior of those receiving HIV prevention. Low education and stigma were mentioned as barriers and needs in rural areas. Attendees stated that methamphetamine use has increased in rural areas and amongst African-Americans, in addition to gay white males. A barrier cited in reaching the incarcerated population for HIV prevention services after their release from prison was the restriction of peer educators and outreach workers from entering the prisons and providing necessary information. Finally, attendees felt that poor communication and decreased funding were barriers in providing linkages between care and prevention.

The results from the 2005 public hearings are consistent with the needs identified in the 2004 SCSN. The need for increased funding, improving provider competency, educating consumers, and improving the integration of services were identified both years. Transportation continues to be of great concern to many consumers, especially in rural regions. Although not a new issue, the need for improved access to substance abuse and mental health services stood out in the 2005 public hearings. Another consistent theme in the public hearings was the need for increased political advocacy to help consumers lobby for change and increased funding.

Unmet Need

Virginia assessed unmet need by using existing surveillance data from the HIV/AIDS Reporting System (HARS) and obtaining additional data from the ADAP and Virginia Client Reporting System (VACRS) databases which are maintained by the Virginia Commonwealth University (VCU) Survey and Evaluation Research Laboratory (SERL). Virginia's unmet need framework is included in Tables 8-13. The VACRS database collects data on all clients served with RWCA Title II consortia and MAI funds as well as some data from Titles I, III and IV. The unmet need estimations were based on the determination of persons "in care" as persons having a viral load, CD4 and/or antiretroviral therapy (ART) administered during the 12 month period from 01/01/04-12/31/04. At present, only detectable viral loads are reportable in Virginia. Undetectable viral loads and CD4 counts are not currently reportable.

To determine the number of persons living with HIV/AIDS, Virginia used the HARS database and included all persons diagnosed with HIV or AIDS while living in Virginia with a mortality status of living. Persons diagnosed elsewhere now living in Virginia were excluded. Persons diagnosed in Virginia, but living elsewhere, were not able to be excluded from the count.

To determine the number of persons with HIV/AIDS in care, Virginia included all persons with a CD4 count or viral load during calendar year 2004 in HARS. HARS collects information about antiretroviral therapy, but does not include dates, so this information could not be used to determine who is presently in care. Additional evidence

of care was obtained by comparing all persons lacking evidence of care in HARS with the ADAP and VACRS databases.

Several factors contribute to the underestimation of the number of individuals receiving care. Because CD4 counts and undetectable viral loads are still not reportable in Virginia, laboratory markers of "in care" are incomplete in HARS. Significant progress has been made however on amending Virginia Regulations for Disease Reporting and Control to make all CD4 counts and viral loads reportable. These changes to the regulations are in the final stages of the approval process. Although excluding cases diagnosed elsewhere and now living in Virginia and including Virginia cases that now live elsewhere should give an accurate estimate of people living in Virginia with HIV/AIDS, both tend to underestimate the percentage of people counted as "in care". Since Virginia cases living elsewhere were included, it is unlikely that information about their care status would be available. This would result in an increase in the denominator (people living with HIV/AIDS) thus lowering the percentage. Also, a person diagnosed elsewhere and now living in Virginia and receiving care would not be included in either the numerator or denominator. All of these factors tend to underestimate the percentage of PLWH/As who are in care.

Virginia did not include Veterans Administration (V.A.) or Medicaid data in the framework. Because both the V.A. and Medicaid information are not client level data, they could not be matched to persons listed in HARS. VDH will continue to work collaboratively with DMAS in order to identify strategies to share data and obtain the client information necessary for the unmet need estimate. Anecdotal information would indicate that a significant portion of individuals reported with unmet need received care from a source that does not provide data to VDH. As other data systems become available for use in estimating unmet need, each system will be assessed independently to determine procedures specific to the individual systems.

Currently, plans are underway to get additional data from Title I-funded providers and infectious disease clinics in Virginia. The incomplete Title I data may explain the higher unmet net need calculated for Northern and Eastern Virginia, which receive significant Title I funding. The high incidence in these regions may also account for the unmet need. (See Table 8.)

In analyzing the unmet need data in Virginia by gender, males have proportionately higher unmet need than females (66.6% vs. 58.2%). (See Table 9.) Further analysis is needed to determine the cause of this difference.

According to the calculations, White, non-Hispanic, Asian/Pacific Islander, and unknown race have the greatest unmet need. This does not reflect the infection rate which is greatest among African-Americans. (See Table 10.) This discrepancy may be due to socioeconomic factors that determine whether or not these populations receive private care or public assistance. For example, persons with high income levels receive care from private sources. Persons with low income are less likely to seek any care and are more likely to drop out of care. The high percent of persons of unknown race with

unmet need may be due to the limited amount of information that was collected from those individuals.

By age at time of diagnosis, unmet need is reported greatest for persons 13-19 and 20-29. (See Table 11.) The absence of Medicaid data may account for persons under 21 years of age, since many persons in this age range are eligible for Medicaid. Those not eligible are more likely to have third-party insurance. For persons 20-29, the unmet need may be because this age group (especially among males) is the least likely to visit their doctor regularly. Youthful notions of invulnerability and overall health may account for tendencies by this age group to not seek medical care.

For unmet care needs by transmission risk, persons of "other" risk were calculated to have the greatest need. (See Table 12.) Included in this category are blood transfusions and hemophilia. As this category represents less than 2% of all reported cases of HIV/AIDS in Virginia, it is difficult to make inferences for the data.

VDH is considering the possibility of the formation of a workgroup to investigate ways to improve data and estimates. Strengthening data sharing agreements between RWCA Titles and other agencies would also enhance the data. Finally, conducting a population-specific needs assessment to better understand barriers to care may help to explain many of the reasons for disparities in unmet need.

Table 7. Virginia HIV/AIDS Unmet Care Needs Assessment.

Population Sizes	**Total**	**Data Source**
A. Persons Living with AIDS	7851	HARS through 12/31/04
B. Persons Living with HIV(not AIDS)	9066	HARS through 12/31/04
Care Patterns		
C. PLWA with met need	3634	
- Viral Loads & CD4s	2158	HARS through 10/31/04
- RW CARE Data	1476	SERL Match
D. PLWHnA with met need	2813	
- Viral Loads & CD4s	1659	HARS through 10/31/04
- RW CARE Data	1154	SERL Match
Calculated Results		
E. Number of PLWA with unmet need (A - C)	4217	
F. Number of PLWHnA with unmet need (B - D)	6253	
G. Total PLWH/A with unmet need (E + F)	10470	
H. Percent of PLWA with met need (C/A)	46.3%	
I. Percent of PLWA with unmet need (E/A)	53.7%	
J. Percent of PLWHnA with met need (D/B)	31.0%	
K. Percent of PLWHnA with unmet need (F/B)	69.0%	
L. Percent of PLWH/A with met need ((C+D)/(A+B))	38.1%	
M Percent of PLWH/A with unmet need (G/(A+B))	61.9%	

Table 8. Virginia HIV/AIDS Unmet Care Needs by Health Region

Population Sizes	Central	Eastern	Northern	Northwest	Southwest
A. Persons Living with AIDS	1689	2305	2403	582	621
B. Persons Living with HIV(not AIDS)	2382	3293	2407	542	693
Care Patterns					
C. PLWA with met need	838	1074	764	302	387
- Viral Loads & CD4s	556	675	461	165	258
- RW CARE Data	282	399	303	137	129
D. PLWHnA with met need	708	825	657	199	276
- Viral Loads & CD4s	467	478	471	102	184
- RW CARE Data	241	347	186	97	92
Calculated Results					
E. Number of PLWA with unmet need (A - C)	851	1231	1639	280	234
F. Number of PLWHnA with unmet need (B - D)	1674	2468	1750	343	417
G. Total PLWH/A with unmet need (E + F)	2525	3699	3389	623	651
H. Percent of PLWA with met need (C/A)	49.6%	46.6%	31.8%	51.9%	62.3%
I. Percent of PLWA with unmet need (E/A)	50.4%	53.4%	68.2%	48.1%	37.7%
J. Percent of PLWHnA with met need (D/B)	29.7%	25.1%	27.3%	36.7%	39.8%
K. Percent of PLWHnA with unmet need (F/B)	70.3%	74.9%	72.7%	63.3%	60.2%
L. Percent of PLWH/A with met need ((C+D)/(A+B))	38.0%	33.9%	29.5%	44.6%	50.5%
M. Percent of PLWH/A with unmet need (G/(A+B))	62.0%	66.1%	70.5%	55.4%	49.5%

Table 9. Virginia HIV/AIDS Unmet Care Needs by Gender

Population Sizes	Male	Female
A. Persons Living with AIDS	5798	1802
B. Persons Living with HIV(not AIDS)	6588	2729
Care Patterns		
C. PLWA with met need	2397	968
- Viral Loads & CD4s	1491	624
- RW CARE Data	906	344
D. PLWHnA with met need	1741	924
- Viral Loads & CD4s	1125	577
- RW CARE Data	616	347
Calculated Results		
E. Number of PLWA with unmet need (A - C)	3401	834
F. Number of PLWHnA with unmet need (B - D)	4847	1805
G. Total PLWH/A with unmet need (E + F)	8248	2639
H. Percent of PLWA with met need (C/A)	41.3%	53.7%
I. Percent of PLWA with unmet need (E/A)	58.7%	46.3%
J. Percent of PLWHnA with met need (D/B)	26.4%	33.9%
K. Percent of PLWHnA with unmet need (F/B)	73.6%	66.1%
L. Percent of PLWH/A with met need ((C+D)/(A+B))	33.4%	41.8%
M. Percent of PLWH/A with unmet need (G/(A+B))	66.6%	58.2%

Table 10. Virginia HIV/AIDS Unmet Care Needs by Race/Ethnicity

Population Sizes	White, non-Hispanic	Black, non-Hispanic	Hispanic	Asian/ Pacific Islander	Am. Indian/ AK Native	Multi-Race	Other	Unknown
A. Persons Living with AIDS	2624	4487	393	79	5	4	0	8
B. Persons Living with HIV(not AIDS)	2677	6036	445	66	8	2	0	83
Care Patterns								
C. PLWA with met need	990	2169	166	31	4	2	0	3
- Viral Loads & CD4s	631	1384	78	14	3	2	0	3
- RW CARE Data	359	785	88	17	1	0	0	0
D. PLWHnA with met need	758	1745	132	16	2	1	0	11
- Viral Loads & CD4s	517	1080	76	16	2	1	0	10
- RW CARE Data	241	665	56	0	0	0	0	1
Calculated Results								
E. Number of PLWA with unmet need (A - C)	1634	2318	227	48	1	2	0	5
F. Number of PLWHnA with unmet need (B - D)	1919	4291	313	50	6	1	0	72
G. Total PLWH/A with unmet need (E + F)	3553	6609	540	98	7	3	0	77
H. Percent of PLWA with met need (C/A)	37.7%	48.3%	42.2%	39.2%	80.0%	50%		37.5%
I. Percent of PLWA with unmet need (E/A)	62.3%	51.7%	57.8%	60.8%	20.0%	50%		62.5%
J. Percent of PLWHnA with met need (D/B)	28.3%	28.9%	29.7%	24.2%	25.0%	50%		13.3%
K. Percent of PLWHnA with unmet need (F/B)	71.7%	71.1%	70.3%	75.8%	75.0%	50%		86.7%
L. Percent of PLWH/A with met need ((C+D)/(A+B))	33.0%	37.2%	35.6%	32.4%	46.2%	50%		15.4%
M. Percent of PLWH/A with unmet need (G/(A+B))	67.0%	62.8%	64.4%	67.6%	53.8%	50%		84.6%

Table 11. Virginia HIV/AIDS Unmet Care Needs by Age of Diagnosis

Population Sizes	0 - 12	13 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60+	Unknown
A. Persons Living with AIDS	93	45	1209	3261	2206	628	158	0
B. Persons Living with HIV(not AIDS)	78	383	3174	3518	1629	412	118	5
Care Patterns								
C. PLWA with met need	28	26	485	1422	1043	290	71	0
- Viral Loads & CD4s	11	17	310	842	682	199	54	0
- RW CARE Data	17	9	175	580	361	91	17	0
D. PLWHnA with met need	36	107	810	1018	509	152	33	0
- Viral Loads & CD4s	18	72	503	666	308	109	26	0
- RW CARE Data	18	35	307	352	201	43	7	0
Calculated Results								
E. Number of PLWA with unmet need (A - C)	65	19	724	1839	1163	338	87	0
F. Number of PLWHnA with unmet need (B - D)	42	276	2364	2500	1120	260	85	5
G. Total PLWH/A with unmet need (E + F)	107	295	3088	4339	2283	598	172	5
H. Percent of PLWA with met need (C/A)	30.1%	57.8%	40.1%	43.6%	47.3%	46.2%	44.9%	
I. Percent of PLWA with unmet need (E/A)	69.9%	42.2%	59.9%	56.4%	52.7%	53.8%	55.1%	
J. Percent of PLWHnA with met need (D/B)	46.2%	27.9%	25.5%	28.9%	31.2%	36.9%	28.0%	0.0%
K. Percent of PLWHnA with unmet need (F/B)	53.8%	72.1%	74.5%	71.1%	68.8%	63.1%	72.0%	100.0%
L. Percent of PLWH/A with met need ((C+D)/(A+B))	37.4%	31.1%	29.5%	36.0%	40.5%	42.5%	37.7%	0.0%
M. Percent of PLWH/A with unmet need (G/(A+B))	62.6%	68.9%	70.5%	64.0%	59.5%	57.5%	62.3%	100.0%

Table 12. Virginia HIV/AIDS Unmet Care Needs by Transmission Risk

Population Sizes	MSM	IDU	MSM/IDU	Hetero.	Other	Pediatric	NIR
A. Persons Living with AIDS	3198	1184	336	1475	98	105	1204
B. Persons Living with HIV(not AIDS)	3263	1208	358	1840	72	79	2497
Care Patterns							
C. PLWA with met need	1252	506	140	759	32	34	642
- Viral Loads & CD4s	751	301	94	468	21	16	464
- RW CARE Data	501	205	46	291	11	18	178
D. PLWHnA with met need	970	297	110	641	16	36	595
- Viral Loads & CD4s	634	182	65	388	12	18	403
- RW CARE Data	336	115	45	253	4	18	192
Calculated Results							
E. Number of PLWA with unmet need (A - C)	1946	678	196	716	66	71	562
F. Number of PLWHnA with unmet need (B - D)	2293	911	248	1199	56	43	1902
G. Total PLWH/A with unmet need (E + F)	4239	1589	444	1915	122	114	2464
H. Percent of PLWA with met need (C/A)	39.1%	42.7%	41.7%	51.5%	32.7%	32.4%	53.3%
I. Percent of PLWA with unmet need (E/A)	60.9%	57.3%	58.3%	48.5%	67.3%	67.6%	46.7%
J. Percent of PLWHnA with met need (D/B)	29.7%	24.6%	30.7%	34.8%	22.2%	45.6%	23.8%
K. Percent of PLWHnA with unmet need (F/B)	70.3%	75.4%	69.3%	65.2%	77.8%	54.4%	76.2%
L. Percent of PLWH/A with met need ((C+D)/(A+B))	34.4%	33.6%	36.0%	42.2%	28.2%	38.0%	33.4%
M. Percent of PLWH/A with unmet need (G/(A+B))	65.6%	66.4%	64.0%	57.8%	71.8%	62.0%	66.6%

Description of the Current Continuum of Care

Ideally, a continuum of care should link HIV/AIDS services in a seamless manner for a consumer accessing the system. Originally, the system was designed to support short-term access to acute care services. With the implementation of highly active antiretroviral therapy (HAART), the needs of individuals living with HIV/AIDS has changed. Today, the system must provide medically complex, chronic care over long periods of time. Without adequate resources or infrastructure to make this transition, the RWCA system has become fragmented, with gaps in care and increasing challenges for clients navigating the system. Fortunately, efforts are being made to better identify the services available and improve the linking mechanisms between them.

I. Prevention Services

In Virginia, the continuum of care starts with prevention and testing. The VDH prevention program is funded primarily through a cooperative agreement with the CDC. Additional support is provided through state funding. The CDC grant supports a range of activities that include: testing and counseling; referral; partner counseling and referral services; health education/risk reduction services; public information; a toll-free hotline; capacity building; technical assistance; training; quality assurance; and evaluation. In compliance with requirements from the CDC, in 1994 VDH formed the Virginia HCPC. It is composed of education and service providers, clients, state agency representatives, clergy, and private citizens affected by HIV, working cooperatively to develop a comprehensive HIV prevention plan for the Commonwealth of Virginia.

The Division of Disease Prevention funds grant programs that target the priority populations identified by the Virginia HCPC: PLWH/A; racial/ethnic minorities; IDU; MSM; heterosexuals; inmates; youth; transgender persons; homeless persons; persons who sell or trade sex; and mentally ill / mentally retarded. More than $3,000,000 is provided annually to community-based organizations and health districts to support prevention programs.

A. Awareness and Education

1. *AIDS Service Organizations*

Established in 1986, the regional AIDS service organization grant program was the first in the state. Funds were divided by region to ensure that every area of the state received at least a baseline of prevention funds. The regional AIDS Service Organizations (ASOs) were required to target at least three populations at increased risk for HIV (including African-Americans), and make efforts to provide services throughout as much of their health region as possible.

As time has gone on, a regional approach has not been as workable as there are numerous community-based organizations within each region now. Due to three consecutive years of funding cuts by the CDC, the ASO grant program was

discontinued. At the same time the budget was being cut, states were being asked to increase resources for primary prevention for people with HIV and to implement rapid testing technology. The OraQuick rapid test costs more than $13 compared to $2.50 for a traditional tests. Rising costs for personnel, rent and other expenses also made it impossible to retain the grant program. Major impact will be felt in rural areas that have no other source of HIV prevention funding, with inmates (education to 20 correctional facilities was conducted under this grant) and African-American women being particularly affected.

2. *Minority AIDS Projects*

First funded in 1988, this program was reorganized in 2004 to expand services. Funds are provided to minority community-based organizations to conduct HIV prevention interventions to racial/ethnic minorities at increased risk for HIV infection. Projects are funded in nine localities with the highest HIV/AIDS morbidity among Black, Latino and Asian/Pacific Islander communities.

3. *AIDS Services and Education Grants*

This program is supported entirely through state funding and was created through an act of the Virginia General Assembly in 1989. These grants are intended to support street outreach, innovative prevention interventions for hard to reach populations as well as case management, volunteer training and support services.

4. *High-Risk Youth and Adults Grants*

Funded in 1997, this grant program targets high-risk youth including incarcerated youth, incarcerated adults, IDUs, people who exchange sex for money or drugs, and the homeless. It was created to address gaps in services identified through the community planning process.

5. *Men who have Sex with Men (MSM) HIV Prevention Program*

Established in 1998, this grant program was created to address a significant disparity between the impact of the epidemic on gay and bisexual men and the amount of funding being targeted to this community. The program has been expanded twice since 1998 with supplemental funds. Populations targeted included racial/ethnic minorities, young men and men on the down low.

6. *African-American and Hispanic Faith Initiative*

Created in 1999, the project grew out of a public call for faith-based HIV programs in minority communities and a series of research and survey projects conducted by VCU-SERL on behalf of VDH and the Virginia HCPC. Through a community-mobilization approach, religious institutions may use funds for clergy

training and congregation education around HIV as well as mentoring of other churches in the development of HIV prevention and support programs.

B. Counseling and Testing

1. *Community HIV Testing Services*

Following a successful pilot program which showed increased testing of high-risk populations and return rates for test results, this grant program was established in 2001 to provide oral HIV antibody testing in outreach and non-invasive settings (such as STD clinics or other locations where blood is already being tested) through community-based organizations. The focus is on reaching MSM, IDUs and the sexual partners of these populations.

2. *Anonymous and Confidential HIV Counseling and Testing*

Testing for HIV is available at anonymous and confidential test sites throughout Virginia. These sites receive federal and state funds to provide free HIV client-centered prevention counseling and serological HIV testing services. In anonymous testing situations, the client does not provide his or her name, nor is it reported. A special code is given to the client before testing so that results may be provided. There are 20 anonymous HIV counseling and testing sites (ATS) across Virginia and several satellite sites. In confidential testing situations, the client provides his or her name for disease control purposes, but the results of the test are confidential. Confidential testing is done at local health departments and clinics throughout the state. There are over 100 VDH-supported confidential test sites in Virginia.

C. Referrals and Linkages to Care

At the anonymous and confidential HIV counseling and testing sites, infected individuals are referred for prompt medical care, preventive, psychosocial, and other needed services to delay further progression of the disease and establish or maintain a high quality of life. Trained personnel assist persons who are HIV-positive by encouraging participation in partner counseling and referral service (PCRS) activities aimed at identifying sex and/or needle sharing partners, referring them for counseling, testing and other referral services.

D. Primary Prevention for Persons Living with HIV

This program, established in 2002, supports primary HIV prevention (prevention of new HIV infections) by working with HIV-infected individuals. Prevention case management is provided to individuals identified as engaging in high-risk behaviors that may transmit HIV, or those with mental health, substance abuse or medication adherence difficulties. Additional strategies include group level interventions and support groups.

II. **Health Care Services**

Once newly-diagnosed persons are identified through testing and counseling services, the goal is to help them find care and stay in care. Early treatment and diagnosis will aid in the prevention of the spread of HIV/AIDS in the general population. To this end, RWCA-funded providers and other agencies work together with medical providers to ensure appropriate, high quality services are provided.

The first contact for a newly-diagnosed individual is often a case management provider funded by one of the RWCA grantees. The case management provider will assist the client to find a medical care provider, make appointments, link the client to ADAP, find transportation and other necessary support services, and provide follow-up. All RWCA grantees provide medical care for low-income and underinsured individuals. Additionally, the state funds three early intervention programs which provide medical care for newly-diagnosed individuals. (See section entitled "Profile of RWCA-Funded Providers" for a more detailed description of RWCA-funded providers and services)

Individuals with more advanced stages of HIV/AIDS may qualify for Medicaid or Medicare. For individuals who are disabled for at least 24 months, Medicare provides health coverage for hospitalization, outpatient medical visits, and other covered services. Low-income individuals in need of nursing facility care may qualify for Medicaid. If eligible, Medicaid would pay for the cost of care in a facility. The Medicaid waiver program provides the opportunity for individuals who may otherwise have been institutionalized in an inpatient hospital or nursing facility to receive home care and other supportive services, in addition to the full range of Medicaid benefits.

For persons living with HIV/AIDS with higher incomes and/or insurance coverage, private clinics and medical providers may provide their primary medical care. It is uncertain exactly how many persons living with HIV/AIDS in Virginia receive their primary care from private facilities. VDH plans to conduct a further analysis of sources of met need in the unmet need estimate to help quantify the role of private providers.

To help persons living with HIV/AIDS confront the rising cost of HAART regimens, there are several types of prescription drug assistance available to Virginians. Beginning January 1, 2006, coverage for dually-eligible Medicare and Medicaid eligible clients will be shifted to Medicare Part D, the prescription drug benefit program. Part D also replaces the Medicare-approved drug discount cards program that ended December 31, 2005. Low-income Medicare beneficiaries may also receive help with prescription drug costs through the Low Income Subsidy (LIS) component of Part D administered by the Social Security Administration. The Virginia ADAP program provides medication for the treatment of HIV/AIDS to individuals without insurance coverage or third party benefits for ADAP medications. ADAP is accessed through local health departments throughout the state. Clients who do not qualify for ADAP are referred to industry-based pharmaceutical patient assistance programs. These programs can be accessed by the client, physician, or case worker.

Due to financial constraints on state and federal programs, if clients exceed their income restrictions, they may lose their eligibility to receive services. This presents a challenge to individuals who may be healthy enough to work at least part time, but are unable to afford the costs for medical care and antiretroviral therapy without financial assistance. Maintaining such individuals in care is a challenge that cannot be easily solved in the current model of health care in the nation.

Resource Inventory

For a visual summary of core medical and support services by RWCA-funded providers and other agencies, please refer to the matrix of HIV health care services. (See Table 13.) In addition to the services described in the matrix, for populations with special needs, the following agencies may also provide medical care and support services:

a. *Department of Corrections (DOC)*

While incarcerated, inmates of state and federal facilities receive primary medical care and medications. The Seamless Transition program, a joint effort between the DOC and VDH, helps provide primary care and medication for persons paroled from their correctional facilities as they re-enter Virginia communities. At least one-month prior to each inmate's release, the DOC medical department will contact the ADAP Coordinator to provide medical information, prescriptions, and establish a follow-up medical appointment. The ADAP Coordinator then forwards the information to the Central Pharmacy and local health department so that the client's medication will be available upon his or her release.

b. *Veterans Affairs (V.A.)*

Veterans may receive HIV prevention and care services through the Department of Veterans Affairs *("V.A." is not to be confused with the abbreviation for the Commonwealth of Virginia).* Most V.A. doctors who treat HIV are specialists in infectious disease. They work with a team of other health professionals who focus on HIV as a chronic, or lifelong, disease. Veterans with HIV can get referrals to mental health professionals, such as psychologists, nurse therapists, clinical social workers, or psychiatrists. Veterans also will likely have a social worker who is part of the HIV clinic where they will receive care. Veterans can also get help for drug abuse. Some V.A. Medical Centers have a support group for veterans with HIV. Finally, the V.A. has Vet Centers, or Veteran Readjustment Centers, that specialize in supporting veterans with post-traumatic stress disorder. Many of these centers provide help to veterans with HIV.

c. *Community Health Centers*

An important safety net, community health centers (CHC) provide health care regardless of ability to pay or lack of health insurance. CHCs provide comprehensive primary care services as well as supportive services such as translation and transportation services that promote access to health care. They are always located in or serve a high need community, i.e. "medically underserved areas" or "medically underserved populations". Their services must be available to all residents of their service areas, with fees adjusted upon patients' ability to pay. Several CHCs are also RWCA Title II subcontractors.

d. *Migrant Health Centers*

Migrant Health Centers (MHC) provide a broad array of culturally and linguistically competent medical and support services to migrant and seasonal farm workers and their families. In Virginia there are several MHCs located in the Eastern Shore and Southwest regions. Some of the RWCA Title II subcontractors work actively with Migrant Health programs to identify and treat HIV-positive workers in migrant camps.

In addition, an extensive listing of statewide HIV-specific services is compiled and maintained by VDH's Community Services Unit. This document, the *Statewide HIV/AIDS Resource and Referral Listings,* is available as a yearly publication posted on the VDH website and is included as Appendix C.

Table 13. Matrix of HIV Health Care Services

REGION	PROGRAM	CORE SERVICES						SUPPORT SERVICES																				
		PRIMARY MEDICAL CARE	HIV RELATED MEDICATIONS	MENTAL HEALTH TREATMENT	SUBSTANCE ABUSE TREATMENT	ORAL HEALTH (DENTAL CARE)	CASE MANAGEMENT	BUDDY/COMPANION	CHILD CARE	CLIENT ADVOCACY	COUNSELING AND TESTING	DAY / RESPITE CARE	DURABLE MEDICAL EQUIPMENT	EMERGENCY FINANCIAL SERVICES	FOODBANK / NUTRITIONAL SERVICES	HEALTH EDUCATION	HEALTH INSURANCE	HOME HEALTH CARE	HOSPICE	HOUSING ASSISTANCE	IN-PATIENT MEDICAL CARE	LEGAL SERVICES / PERMANCY PLANNING	OUTREACH (CASE FINDING)	REHABILITATIVE SERVICES	SUPPORT GROUPS	TRANSLATION SERVICES	TRANSPORTATION	TREATMENT ADHERENCE
STATEWIDE (ALL REGIONS)																												
	MEDICAID	X	X	X		D							X					X	X		X			X			X	
	AIDS WAIVER						X					X			X			X										
	HIPP																X											
	DMHMRSAS			X	X		X				X			X														
	VHARCC															X												
	AETC															X												
	ADAP		X																									
NORTHERN																												
	TITLE I	X	X	X	X	X	X		X					X	X		X					X			X	X	X	
	TITLE II	X	X	X		X	X																X					
	TITLE III	X	X			X	X				X																	
	TITLE IV	X		X			X			X	X																	
	HOPWA								X											X		X					X	
NORTHWEST																												
	TITLE I [1]	X	X		X	X	X							X	X							X					X	
	TITLE II	X	X	X	X	X	X			X	X			X	X					X			X		X		X	
	TITLE III	X	X	X	X		X			X	X				X						X					X	X	
	HOPWA						X							X	X					X								
SOUTHWEST																												
	TITLE II	X	X	X		X	X			X			X														X	
	TITLE III	X				X																						X
	HOPWA						X							X	X					X					X		X	
CENTRAL																												
	TITLE II	X	X	X	X	X	X	X	X	X	X	X		X	X			X		X		X	X	X	X	X	X	X
	TITLE III	X	X	X	X	X	X	X			X		X		X	X							X			X	X	
	TITLE IV	X		X		X	X		X	X			X					X				X	X		X		X	
	HOPWA				X		X							X	X					X					X		X	
EASTERN																												
	TITLE I [2]	X	X	X	X	X	X			X				X	X					X			X			X	X	X
	TITLE II	X	X	X		X	X						X	X	X					X		X	X		X	X	X	X
	HOPWA						X		X					X	X					X					X		X	

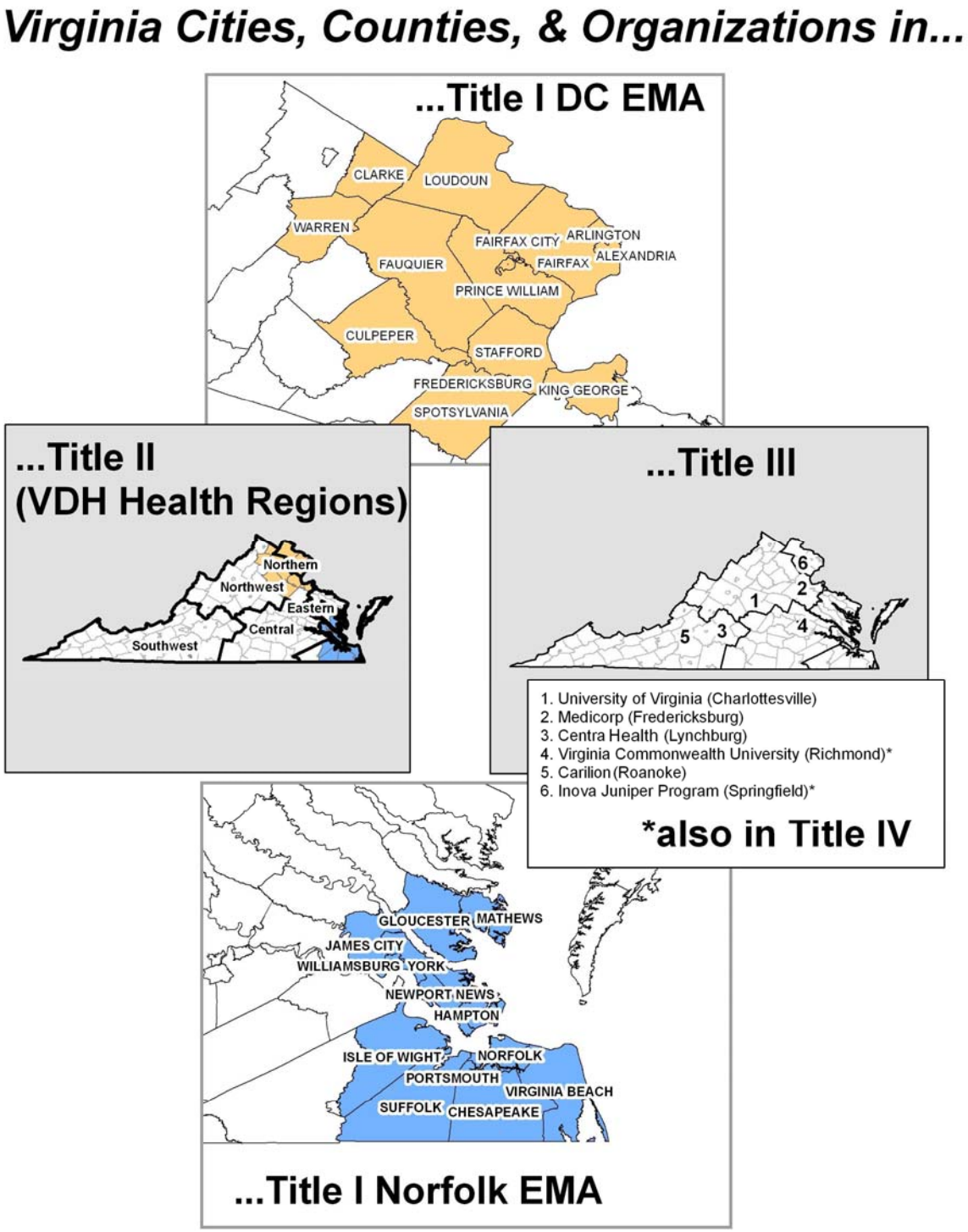
NOTES: D = UNDER AGE 21

1 NW TITLE I IS LIMITED TO STAFFORD, CLARKE, FAUQUIER, WARREN, SPOTSYLVANIA, & CITY OF FREDERICKSBURG

2 E TITLE I IS LIMITED TO CITIES OF CHESAPEAKE, HAMPTON, NEWPORT NEWS, NORFOLK, POQUOSON, PORTSMOUTH, SUFFOLK VIRGINIA BEACH, WILLIAMSBURG, AND COUNTIES OF ISLE OF WIGHT, JAMES CITY, GLOUCESTER, MATHEWS, AND YORK.

Profile of RWCA-Funded Providers

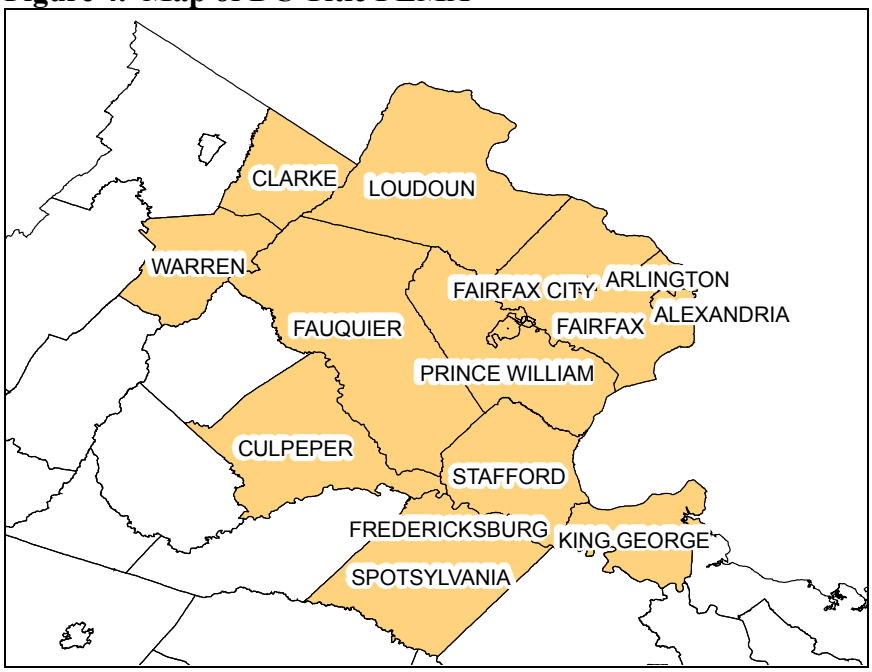
Figure 3. Map of RWCA Titles in Virginia



Title I

Title I provides emergency assistance to urban areas most severely affected by HIV. In Virginia, the northern and northwest regions of the state include a significant portion of the Washington, DC EMA. The Norfolk EMA is located in the eastern region.

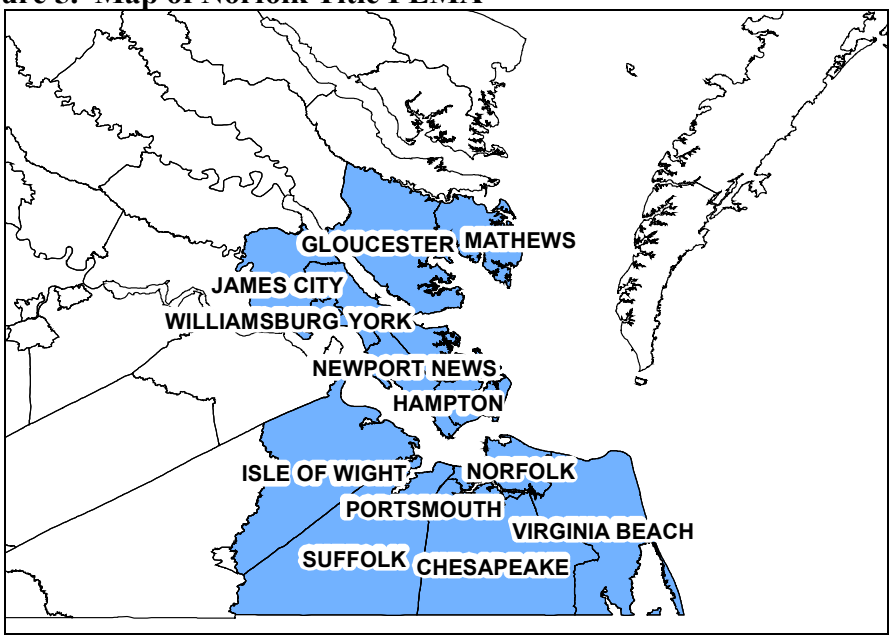
Figure 4. Map of DC Title I EMA



1. Washington, DC

The DC EMA provides funding for services to HIV-infected individuals and their families in northern and northwestern Virginia - including the counties of Arlington, Clarke, Culpeper, Fairfax, Fauquier, King George, Loudoun, Prince William, Spotsylvania, Stafford, and Warren - and the cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, and Manassas Park. Title I services include primary medical care, case management, non-ADAP drug assistance, dental services, mental health services, discharge planning, substance abuse services, transportation, home-delivered food, child/day care, health insurance co-pays, food vouchers, nutritional support and counseling, interpreter services, and legal services. The same administrative agency, the Northern Virginia Regional Commission, manages Title I and II funds thereby avoiding unnecessary duplication or omission of services.

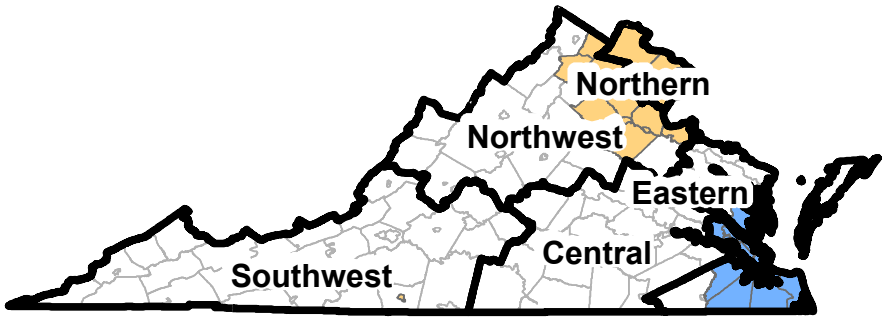
Figure 5. Map of Norfolk Title I EMA



2. Norfolk

The Norfolk EMA encompasses the Greater Hampton Roads area of Virginia and the coastal county of Currituck, North Carolina. In Virginia, the Greater Hampton Roads region includes the cities of Chesapeake, Norfolk, Portsmouth, Suffolk, Virginia Beach, Hampton, Newport News, Poquoson, and Williamsburg, and the counties of Isle of Wight, James City, Gloucester, Mathews and York. Title I services include primary care, case management, HIV-related medications, emergency financial aid, oral health, transportation, housing, outreach/case finding, client advocacy, mental health, substance abuse, nutrition, legal/permanency planning, translation, treatment adherence, and capacity building. A memorandum of understanding (MOU) has been established between Title I and Title II that describes how these funding streams interrelate.

Figure 6. Map of RWCA Title II in Virginia (VDH Health Regions)



Title II

RWCA Title II funds services to improve access to primary medical care and support services that enhance access to and retention in primary care. The Division of Disease Prevention of VDH administers these funds. VDH divides the state into five regions: Northern, Northwest, Southwest, Central, and Eastern. Each health region in Virginia has a lead agency and regional consortium that coordinates and facilitates the RWCA Title II funds awarded to the region and serve as a point of contact for information on accessing Title I, III and Title IV funds that may also exist in the region. VDH looks at all funding sources available in a region when allocating Title II funds. Ongoing challenges faced by Title I and III-funded programs have negatively impacted overall service access. Attempts to mitigate the impact of these challenges by reallocation of Title II funds have been of limited value due to the insufficient resources available to VDH.

1. Northwest

James Madison University serves as the lead agency for the region funding six Title II providers. Four regional ASOs are key service providers to this largely rural area. There is little infrastructure so services such as transportation are very scarce. Most medical care is provided through the Title III programs at the University of Virginia (UVA) in Charlottesville and at Medicorp in Fredericksburg. Sequential shifting of Title III funding between grantees in the western part of the state by HRSA is having significant impact on regional access to primary medical care.

2. Northern

Geographically, Northern Virginia has the smallest area, but the highest population density. The area is ethnically diverse and predominantly urban. It includes three Title II-funded providers and one Title II-funded MAI provider. The region has very effectively integrated planning and allocations across Titles so there is no duplication and the administrative burden on providers is kept to a minimum. Access to services has been significantly impacted by the threatened closure of Whitman-Walker Clinic's Northern Virginia site which relies heavily on Title I funding. It is now being kept open with funding from several Virginia localities but the future of service delivery at this site remains uncertain. This situation has strained the resources of other medical providers in the region. Due to the very high cost of living in the Northern region, the area has significant difficulty finding affordable housing for PLWH/As. The increase in numbers of PLWH/As has caused decreases in RWCA funding for all support services as RWCA funding is increasingly diverted to primary medical care. The main substance abuse service provider for the region has terminated its contract with the RWCA programs due to lack of funding allocated to this service.

3. Southwest

This region is the largest and most rural of the state. It borders four other states (North Carolina, Tennessee, Kentucky, and West Virginia). The Council of Community Services serves as the lead agency for the region funding seven Title II providers. Like Northwest, the region has been significantly impacted by the uncertain status of Title III funding. The significant loss of Title III funding in the Roanoke area has directly impacted access to primary medical care. Waiting time for appointments for new clients in Roanoke is now 6 weeks. VDH used state funds to establish a new early intervention program to respond to the loss of Title III funding; however inadequate funding is available to fill the gap. Although the region prioritizes its Title II funding to the most critical core services, aggressive restrictions on medication assistance and dental care, as well as many support services, have proved necessary. The exception is transportation, which is vital to maintain access to services in this area of the state. Also, this very large rural area has difficulty retaining case managers so providers have relied on client advocates to help clients negotiate care systems. This approach has enabled clients to receive needed services and has helped the region save money that could be redirected to vital core services.

4. Central

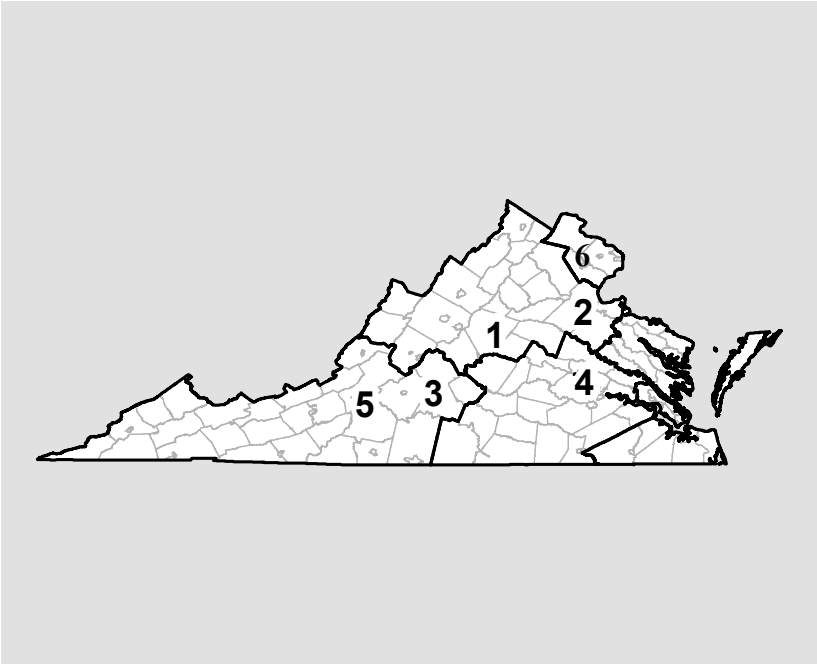
The Community Health Research Initiative (CHRI) of VCU serves as the lead agency in the Central region providing Title II funds to 28 providers including 5 pharmacies and 10 transportation agencies. The VCU Health System (VCUHS) is the largest provider of HIV medical care in the region. CHRI also administers the region's Emerging Communities (EC) funding (a supplemental grant through Title II targeting cities with 500-1,999 reported AIDS cases in the most recent 5 years) as well as its Title III grant which is used for providing early intervention services (primary medical care) within three existing satellites sites in order to identify individuals with the HIV/AIDS and provide them with care at the earliest stage of their disease. The region's close collaboration is exemplified by the Family AIDS Clinic at VCUHS which is a Title IV grantee providing primary medical care to women, infants and children. The Family AIDS Clinic works closely with Title III and receives Title II funding to further support its services.

5. Eastern

Eastern Virginia Medical School serves as the lead agency in the region and funds four Title II providers. The region also has a MAI provider which works collaboratively with both Title I and Title II. The Eastern Shore of Virginia is included in the region. The Eastern Shore is separated from the rest of the state by the Chesapeake Bay Bridge and Tunnel (cost to traverse the bridge is $20). This causes major problems for access to medical care for residents of the shore. The major medical provider is located in Norfolk. To alleviate access issues, the medical program sends doctors and nurse practitioners out to rural sites, including the Eastern Shore in order to hold clinics. The region has historically found collaboration

between Title I and II to be challenging. Over the past year, this relationship has improved significantly and now much improved bilateral communication, planning and needs assessments occur.

Figure 7. Map of RWCA Title III in Virginia



1. UVA (Charlottesville)

2. Medicorp (Fredericksburg)

3. Centra Health (Lynchburg)

4. VCU (Richmond)*

5. Carilion (Roanoke)

6. Inova Juniper Program (Springfield)*

* Also receives Title IV

Title III

Title III provides direct funding to clinics and other providers for comprehensive primary health care for individuals living with HIV disease. The early intervention services include risk-reduction counseling, antibody testing, medical evaluation, and clinical care; antiretroviral therapies; protection against opportunistic infections; ongoing medical, oral health, nutritional, psychosocial, and other care services for HIV-infected clients; case management to ensure access to services and continuity of care for HIV-infected clients; and attention to other health problems that occur frequently with HIV infection, including tuberculosis and substance abuse. There are currently six Title III providers in Virginia. Two are university based: UVA in Charlottesville and VCU in Richmond. Four are located in community health systems: Inova Juniper Program in Springfield, Medicorp in Fredericksburg, Centra Health in Lynchburg, and Carilion in Roanoke. A representative from each Title III is a member of each consortium to facilitate referrals into appropriate services for newly-diagnosed clients. In the central region the same program director manages both Title II and Title III funds which facilitates coordination of services.

Title IV

Title IV provides direct funding to clinics and other providers for enhancing client access to care and research for women, infants, children and youth. Services include: primary and specialty medical care; psychosocial services; logistical support and coordination; and outreach and case management. A special focus of the Title IV program is to help identify HIV-positive pregnant women and connect them with care that can improve their health and prevent perinatal transmission. There are currently two Title IV providers in Virginia, Inova Juniper Program in northern Virginia, and VCU in central Virginia.

AIDS Education and Training Center (AETC)

The Virginia local performance sites of the Pennsylvania/MidAtlantic AETC provides custom-designed clinical training and technical assistance to support, motivate and educate physicians, nurses, physician assistants, dental professionals, pharmacists, advanced practice nurses, and other members of the clinical team to provide quality HIV care. The grantee is located in Pittsburgh, Pennsylvania, but there are two local performance sites in Virginia: Inova Juniper Program in northern Virginia, and VCU in central Virginia.

Table 14. Summary of RWCA Titles in Virginia

Funding Stream	Description	Type of Recipient	Impact on Virginia			
			Recipients	2003 Award	2004 Award	2005 Award
Title I	provides emergency assistance to urban areas most severely affected	Eligible Metropolitan Areas (EMAs)*	Norfolk EMA Northern and portions of Northwest regions through DC EMA	$5,168,622 $4,222,232	$4,820,201 $3,952,335	$4,726,063 $4,164,593
Title II	funds services to provide medications, improve health care and support services	States and Territories	Commonwealth of Virginia Administered by VDH	$22,152,113	$22,525,348	$22,679,750
Title III	funds comprehensive primary health care for individuals living with HIV disease	direct funding to clinics and other providers	Carilion, Centra Health, UVA, VCU, Inova, Medicorp	$2,580,027	$2,611,1881	$2,463,520
Title IV	enhances client access to care and research for women, infants, children and youth	direct funding to clinics and other providers	Inova VCU	$819,039	$858,391	$858,391

Barriers to Care

From the 2004 SCSN, one of the top prioritized barriers and gaps was **funding**. Not only was the lack of funding for medical care and ancillary services noted, but also the inability of participants to pay deductibles, co-pays or out-of-pocket expenses for services such as dental restorative care or medications not related to HIV disease. The participants saw the lack of financial support for services restricting infected and affected individuals from needed and/or desired services. Many SCSN participants noted that some medical care providers and support service providers had waiting lists for care.

As currently funded, access to primary medical care is inadequate to serve all individuals eligible for RWCA services. This need has been most acute in Northern Virginia where, over the last year, there has been a waiting list of as long as 4-6 weeks for clients to access primary medical care. In 2005, a major service provider announced plans to eventually close its satellite clinics in Maryland and Virginia in response to a financial crisis. Although the clinic in northern Virginia will be kept open for at least another year, if it closes, it will leave hundreds of clients potentially without a source of medical care. Other regions of the state are also beginning to experience longer waiting times for medical appointments as RWCA-funded services reach and exceed the capacity they are able to serve. Recent shifts in Title III funding have increased the challenge of ensuring access to HIV-related primary care across the state. One result has been a substantial loss in funding for the Roanoke area that will directly impact access to primary medical care. Currently the waiting time for a medical appointment for a new client is about 6 weeks. Despite attempts by VDH to mitigate the impact of the funding loss by shifting Title II and state funds to the area, the available resources are inadequate to maintain the current level of services.

Accessibility was another critical barrier from the 2004 SCSN. A priority barrier participants wanted to address was accessibility of medication. Although Virginia does not have an ADAP waiting list, the situations in neighboring states have made some consumers concerned. For many of the rural areas, availability of affordable and convenient transportation remained the primary barrier to accessing needed medical services. It was within this barrier that participants identified how the lack of funding and availability of transportation also played into their inability to access medical care and support services. Access to services was also limited by political red tape, agency politics and lack of monitoring of professional standards.

Related to professional standards, SCSN participants noted the **need for more knowledgeable and culturally competent providers** (both medical and support service providers). Participants saw the lack of cultural competency and skills training as a barrier to receiving quality care. Another level to this barrier was the need for Spanish-speaking providers and available translation services. Some noted that they had been denied support services (such as food) because of their HIV status. Stigma was one of the most frequently mentioned barriers for preventing access to both medical and support services.

The most discussed barrier/gap among the groups was **case management service** itself. Participants stated that the quality of case management services was affected by high case loads, resulting in case managers being overworked, and experiencing burnout. They also identified that case managers need a consistent statewide training and certification process followed by monitoring of performance against the state case management standards.

For the complete description of barriers to care, please refer to the 2004 SCSN document, pages 23 to 29.

Challenges to ADAP and the Impact of Medicare Part D

ADAP's current challenges are significant and include increased demands on the program and uncertain funding prospects in the future. Although HIV infection rates have decreased, new ADAP enrollments have remained stable while discharges have slowed, resulting in longer enrollment durations and net program growth (See Table 6). The impact of the new Medicare Part D Prescription Drug Benefit on Medicare eligible ADAP clients will also be significant. High Part D client cost-sharing requirements and the tiered structure of the benefit create a potential barrier to uninterrupted access to HIV treatment.

The Medicare Modernization Act (also known as Medicare Part D) will have significant impact on Virginia ADAP. The cost-sharing requirements of Medicare Part D create a barrier to accessing critical medications used to treat HIV and its complications, currently available to ADAP clients at no out-of-pocket expense. Interruption of HIV treatment represents a significant threat to individuals as well as public health. This has caused VDH to investigate options for assisting Medicare-eligible ADAP clients with premiums, co-insurance, and co-pays in order to mitigate the barrier presented by these client cost-sharing requirements.

Based on currently available information, VDH estimates that 10.8% (370) of ADAP clients are Medicare beneficiaries. All Medicare-eligible ADAP clients will be required to show proof of enrollment in a Part D prescription drug plan by the end of the open enrollment period (May 15, 2006) in compliance with HRSA's directive. In addition, Virginia will require all clients with incomes below 150% FPL to apply for the Part D LIS.

A significant proportion (approximately 40% or 150) of these clients are or will become dually eligible for Medicaid and Medicare during the course of the next grant year. These clients, as well as other LIS recipients with incomes below 135% FPL, will be transitioned from ADAP to the Medicare Part D prescription program. LIS eligible clients with incomes between 135-150% FPL may continue to access medications through ADAP if they are unable to meet client cost-sharing requirements and would therefore lose access to antiretroviral therapy. An eligibility exception process will be implemented that will document the client's ongoing need for access to ADAP. Clients

who do not qualify for LIS and otherwise meet ADAP eligibility criteria will be able to continue accessing medications through ADAP in order to avoid interruption in access to antiretrovirals that may result from Part D's high client cost-sharing requirements.

Although ADAP is allowed to cover out-of-pocket costs if the cost neutrality requirement is met, doing so will prevent individuals from reaching Part D's catastrophic coverage level since ADAP expenditures can not be counted toward the Part D out-of-pocket cost requirement. Establishing a new State Pharmaceutical Assistance Program (SPAP) is a possible option to substantially increase savings to ADAP while assisting clients with the cost-sharing burden. SPAP funds used to assist clients with their share of costs count toward the out-of-pocket incurred cost requirement that provides access to catastrophic coverage. VDH has provided information on SPAPs to the 2006 General Assembly, but it will not be known until March whether the General Assembly will approve creating a SPAP.

Section 2. Where do we need to go: What system of care do we want?

Shared Vision for System Changes

Ideally, a continuum of care links HIV/AIDS services in a seamless manner for a consumer accessing the system. Originally, this system was designed to reflect a linear progression of the disease, from infection to end-stage illness and death. Today, with advancements in antiretroviral therapies, the health and well being of persons living with HIV/AIDS do not usually follow a linear progression. As a result, the medical and social service needs of clients have increased in complexity. Without adequate resources or infrastructure to make this transition, the RWCA system has become fragmented, with gaps in care and increasing challenges for clients navigating the system. Fortunately, efforts are being made to better identify the services available and improve the linking mechanisms between them.

Shared Values for System Changes

The following shared values are principles that help guide the continuum of care in Virginia:

- Access
- Equity
- Excellence
- Collaboration
- Empowerment

Access

Ensuring access to primary medical care and antiretroviral medications is the most important value for the continuum of care. Access to care is essential to extend and improve quality of life for HIV-positive individuals. Ideally, primary medical care should be initiated within two weeks of a new diagnosis. To ensure access to care, all efforts must be taken to avoid having waiting lists. Cost-saving measures and redistribution of funds should occur before a waiting list is ever created. However, in the case of waiting lists, those with advanced stages of disease must have priority. Interruption of HIV treatment represents a significant threat to individual as well as public health.

Equity

Access to services for all PLWH/As must be equitable. Neither age, race, ethnicity, gender, sexual orientation, religion, socioeconomic status, residence, language nor physical appearance should be barriers to care. Care providers should be both culturally competent and non-judgmental. Services should be client-centered and

accessible for persons with physical disabilities, language barriers, and in need of services after regular hours of operation.

Excellence

Each PLWH/A should have access to a quality of medical care and support services consistent with appropriate standards and guidelines. Protocols and policies must be established and implemented to ensure excellent services are provided to clients. Providers must be properly trained and competent to deliver the most appropriate level of care for the appropriate amount of time to all clients. Technical assistance should be available to enhance provider performance.

Collaboration

For clients to move fluidly through a continuum of care, there must be communication and collaboration from one service or agency to another. The system should be able to seamlessly link PLWH/A into a wide array of services to cover complex needs. In addition to core services, integral HIV care should incorporate prevention services, substance abuse, mental health, and housing.

Empowerment

As services move away from being centrally located and HIV-specific to integrating with existing community services for the general public, there is an increased need for client empowerment and advocacy to maneuver through the network of services. Clients must be educated about their rights, responsibilities, service options, and opportunities for involvement.

Section 3. How will we get there: How does our system need to change to assure availability of and accessibility to core services?

In the planning process, a dichotomy exists between needed services and available funding. Because of the increasing case load, along with flat or decreased funding, many idealistic goals have proved unattainable. With an uncertain future as funding decreases, RWCA monies are being focused more and more exclusively on HRSA-defined core services (primary medical care, medications, case management, substance abuse treatment, mental health and oral health). The access to other non-core yet essential services, such as transportation and translation, is dependent on available funding, since RWCA is a payer of last resort, and not an entitlement. Many of the gaps in services and needs identified in the 2004 SCSN represent long term challenges. To possibly meet this wide array of needs, additional agencies and funding streams other than RWCA must be utilized. No available resource should go untapped. Needs and gaps in services must be met, regardless of the funding source.

Based on needs identified across the Commonwealth of Virginia through the SCSN process and numerous factors described in this document related to epidemiological trends and characteristics of subpopulations most affected by the HIV epidemic in Virginia, the following broad long-term goals have been established by the SCP Advisory Committee to guide priority setting:

I. Provide equitable access to services for all PLWH/As – regardless of age, race, ethnicity, gender, sexual orientation, religion, socioeconomic status, residence, language and physical appearance.

II. Increase collaboration between care and prevention to increase healthy behaviors among HIV-positive individuals and reduce the transmission rate of new HIV infections.

III. Ensure that HIV-positive individuals receive optimum health care and support services that extend and improve quality of life.

Additional system-level goals include ensuring that service providers are competent, proficient, and culturally sensitive. Primary medical care should be initiated within two weeks of a new diagnosis. Access to antiretroviral medications must be ensured. Care standards must be consistent with RWCA and United States Public Health Service (USPHS) guidelines. More culturally sensitive providers from all ethnic groups should be trained, encouraged, and supported. While "one-stop shops" for services would be ideal and the most convenient for clients, it has proved an elusive goal. As services move away from being centrally located and HIV-specific to integrating with existing community services for the general public, there is an increased need for client empowerment and advocacy to maneuver through the network of services. Clients must be educated about their rights, responsibilities, service options, and opportunities for involvement.

Outline of Goals, Objectives, and Activities

I. Provide equitable access to services for all PLWH/As – regardless of age, race, ethnicity, gender, sexual orientation, religion, socioeconomic status, residence, language and physical appearance.

A. Assess current level of access to services for special populations
   1. Identify potential data sources for HIV-related service information and in-care indicators.
      a. All RWCA-funded Titles
      b. HOPWA
      c. State-funded Early Intervention Programs
      d. State-funded Indigent Care Programs
      e. Medicaid
      f. Medicare
      g. HIV Surveillance
      h. Veterans Affairs
      i. Department of Corrections
      j. Other sources
   2. Increase data sharing between identified data sources through establishing formalized agreements with all identified agencies.
      a. Develop data sharing guidelines to address concerns related to confidentiality, use of shared data, technical aspects of sharing data or other identified barriers to sharing.
      b. Utilize SCP Advisory Committee members to identify appropriate agency contact points to initiate agreements.
      c. Provide information to potential collaborators on the mutual benefits of sharing data for the purpose of accurately assessing access to services and unmet needs.
      d. Implement data sharing components of VDH Memorandum of Agreement with DMAS.
         i. Assess current Memorandum of Agreement with DMAS to determine if changes are needed.
         ii. Revise and improve memorandum as needed
         iii. Implement Memorandum of Agreement
      e. Establish and implement agreements with additional agencies.
   3. Examine and evaluate methodologies increasing utilization of alternate (cumulative) data sources to increase accuracy of Unmet Need Estimate.
      a. Consult with Norfolk Title I EMA regarding HRSA approved methodology utilized in 2006 Title I application.
      b. Consult with Washington DC EMA to compare its methodology with VDH approach.
   4. Assess levels of access to service for special populations.
      a. Identify available data fields for shared data sources providing descriptive information related to populations at risk for access disparities.

b. Analyze census data, epidemiologic data, service data from shared sources, and unmet need estimate.
    i. Compare and contrast population characteristics for individuals receiving services, individuals with unmet need and epidemiologic profile.
    ii. Identify special populations under-represented in services data or over-represented in unmet need estimate.

B. Increase and strengthen opportunities for direct client feedback on access and barriers to services.
    1. Collect, analyze, and compare current client satisfaction surveys in use among Title II-funded service providers.
    2. Identify and evaluate components of surveys addressing access to services.
    3. Present findings to RW Subcommittee of the Virginia HCPC.
        a. Solicit recommendations from the committee for standardized survey questions.
        b. Implement in following year's client satisfaction survey process.
        c. Compile and report statewide survey results for these items to the RW Subcommittee.
        d. Obtain recommendations from the RW Subcommittee on usefulness of information obtained and next steps in assessing access.
        e. Solicit recommendations from the committee for additional methods to solicit feedback from clients on issues impacting access to services, including the use of population specific focus groups.
    4. Obtain Peer Review Committee input on mechanisms to obtain direct client input on service barriers and access issues.
        a. Evaluate potential role of client interviews conducted as part of Peer Review Site Visits to obtain client input.
        b. Identify and evaluate additional methods to identify access issues and barriers from the client perspective such as the use of index or test patients, implementing patient tracer methodology, utilizing a hotline or similar anonymous reporting mechanisms to identify problems.
    5. Disseminate findings from items B.3-4 to all Title II consortia and providers, other RWCA-funded planning bodies and providers, local performance sites of the AETC, the Virginia HIV/AIDS Resource and Consultation Center (VHARCC) and other interested stakeholders.

C. Empower clients by equipping them with knowledge about their service-related rights and responsibilities as well as avenues for recourse to effectively address service access barriers and issues.
    1. Collect, analyze, and compare current rights and responsibilities statements/policies in use among statewide HIV service providers.
    2. Assess the current role of client/peer advocates and related service providers in educating clients on service-related rights, responsibilities, and recourse.

3. Develop client brochure for statewide use addressing HIV service-related rights, responsibilities, and recourse related to service access and equitable treatment.
4. Add related informational resources and links to VDH website, including links to regional grievance procedure information, legal resources, and advocacy groups.

D. Increase collaboration between HIV service providers and local special interest groups representing potentially underserved populations.
   1. Assess outreach by consortia and planning councils to non-participating agencies
   2. Increase recruitment of previously untapped special interest groups such as minority or ethnicity-based community groups, faith-based organizations, and special population advocacy groups)
   3. Assess and compile information on capacity building trainings, technical assistance and support available to these groups.
      a. Through collaboration with the VDH Community Services Unit, encourage participation by these groups in existing trainings.
      b. Facilitate access by these groups to AETC, HOPWA, and other existing resources providing capacity building support.
      c. Utilize VDH website to provide information about and links to capacity building resources.

E. Address language barriers to improve access to services for non-English speaking clients.
   1. Assess current translation needs
      a. Identify data sources (refer to A.1.) that quantify the number of limited English proficiency clients and/or their translation needs.
      b. Assess current language capabilities and translation resources of HIV service providers.
      c. Assess language capability of hotline and provider lines
   2. Develop agency-specific system plans
      a. Develop procedures for addressing language barriers.
      b. Develop list of resources for translational needs.
      c. Increase linkages with local Area Health Education Centers for translation services.
   3. Increase recruitment of multilingual providers
      a. Identify candidates with assistance of ethnic/cultural committees
      b. Develop a directory of multilingual providers
      c. Include language capabilities of service providers in the statewide resource directory.

F. Enhance provider skills abilities and effectiveness in working with diverse and under-served populations in order to reduce barriers to services.

1. AETC and VHARCC will include assessment of provider learning needs related to cultural competence and serving diverse and under-served populations in overall statewide assessment of provider learning needs.
2. Refer findings of learning needs assessment to Peer Review Committee for recommendations on including this in standards.
3. AETC and VHARCC will report findings to VDH and develop statewide training plan to address identified needs related to improving cultural competency and ability to effectively address issues related to sexual diversity.
4. AETC and VHARCC will provide consultation and technical assistance for providers to address related client issues as they occur.

II. Increase collaboration between care and prevention to increase healthy behaviors among HIV-positive individuals and reduce the transmission rate of new HIV infections.

A. Increase the number of HIV-positive individuals being referred to care/ treatment.
   1. Increase the number of individuals aware of their HIV status.
      a. Continue prevention initiatives for increased public awareness/ education of risk behaviors
      b. Continue outreach efforts for testing and counseling
   2. Assess linkage of HIV-positive individuals into care.
      a. Add linkage focus groups in regional needs assessments
      b. Include linkage component in regional client satisfaction surveys
      c. Survey and interview Virginia HCPC members
   3. Based on results from assessment, identify gaps in services and other factors hampering linkage of HIV-positive individuals into care
      a. Identify gaps for HCPC defined priority populations (racial/ethnic minorities; IDUs; MSM; heterosexuals; inmates; youth; transgender persons; homeless persons; persons who sell or trade sex; and mentally ill/mentally retarded)
      b. Identify gaps for any other hard-to-reach populations (rural, migrant, undocumented, etc.)
   4. Examine and evaluate strategies to improve linkage of newly-diagnosed and out of care individuals into primary medical services
      a. Evaluate impact of CDC Linkages to Care Demonstration Project on access to care
      b. Evaluate impact of Seamless Transition program in linking incarcerated populations to care after release from prison
   5. Determine if linkages were successful by measuring number of newly-diagnosed referred to care.
      a. Assess need to replicate CDC Linkages to Care intervention in other areas of the state.
      b. Assess possibility of expanding Seamless Transition to local/regional jails.

6. Increase knowledge among prevention providers of care services available in their area/region.
    a. Utilize VDH HIV Health Care Planner to provide updates at prevention quarterly contractors meetings and Virginia HCPC meetings
    b. Utilize VDH website to increase accessibility of resource inventory for care services

B. Increase healthy behaviors among HIV-positive individuals to reduce the transmission rate of new HIV infections
    1. Increase utilization and awareness of prevention for positives services to promote ownership and responsibility for HIV-positive individuals.
        a. VDH Community Services Unit will survey prevention providers to determine capacity of prevention case managers, peer educators, and adherence counselors
        b. VDH & SERL will conduct data analysis to measure utilization of prevention for positives services
        c. RW Subcommittee of the HCPC will develop client survey to measure awareness of prevention for positives services
        d. If there is available capacity, VDH Community Services Unit will instruct prevention for positives providers to increase advertisement of their services
        e. VDH HIV Prevention Community Planner will provide updates on prevention for positives services at RW Title II Quarterly Contractors' Meetings
    2. Increase the number of care providers offering prevention messages to those that are HIV-positive.
        a. The RW Subcommittee of the Virginia HCPC will assess current practices among care providers.
        b. The RW Subcommittee will present findings to VDH and the Peer Review Committee.
        c. The Peer Review Committee will define what should be contained in a prevention message.
        d. VDH will include updated requirement and definition in contracts with care providers.
        e. Local performance sites of the AETC will provide training for care providers on appropriate methods of delivering prevention messages and addressing substance abuse issues.
        f. Local performance sites of the AETC will provide technical assistance to care providers.

III. Ensure that HIV-positive individuals receive optimum health care and support services that extend and improve quality of life.

A. Ensure access to primary medical care within two weeks of initial contact with the care system

1. Collect, analyze, and compare current waiting times for clients to access primary medical care
    a. Identify trends by population characteristics, regions, funding sources or other contributory factors
    b. Examine methods to minimize waiting times for access to services
    c. Establish waitlist guidelines
2. Determine need for expanding capacity
    a. Explore role of non-specialist providers to expand capacity
    b. Survey clients' acceptance of referral to non-specialist providers
    c. Study role of increased reimbursement rates to expand capacity

B. Ensure uninterrupted access to antiretroviral medications
    1. Collect, analyze, and compare data on current client access to antiretroviral medications.
        a. Identify trends by population characteristics, regions, funding sources or other contributory factors
        b. Examine methods to ensure access
    2. Develop strategies to effectively integrate with Medicare Part D and other payer sources
        a. Establish state pharmaceutical assistance program
        b. Explore increased collaboration with third-party charities
    3. Encourage providers to make cost-effective choices when prescribing
        a. ADAP Advisory Committee will develop suggested cost-effective regimens based upon current prescribing patterns. An analysis of current regimens will be done to determine cost of treatment per patient and to be in compliance with recommended current HIV treatment guidelines.
        b. AETC and VHARCC will provide training for providers to implement cost-effective regimens based upon medication prescribing patterns. Training will incorporate suggested cost effective regimens and strategies from the ADAP Advisory Committee and current HIV treatment guidelines.

C. Ensure access to essential support services that enhance access to primary medical care
    1. Increase knowledge of community services not funded by RWCA.
        a. VDH will investigate use of statewide information and referral program.
        b. Consortia will conduct survey of non-funded services including eligibility and application requirements.
        c. Consortia will include goal in grant applications addressing increased use of non-funded programs for support services.
        d. Each Consortium will recruit one new non-funded provider as a member.

e. At least 3 regions will include information on non-funded providers in their informational materials for clients, including Consortia web sites.
f. Each Consortium will recruit a second new non-funded provider as a member.

2. Increase number of clients using non RWCA-funded programs for support services
   a. VDH will add fields to VACRS to capture information on use of non-funded providers
   b. Consortia will include information in monthly report or in VACRS on use of non-funded providers.
   c. VDH will develop policy on referring to non RWCA-funded providers before utilizing RWCA funds for support services.
   d. RWCA providers will refer clients to non-funded providers for support services before using RWCA funds.

D. Assess response of case management to a shifting HIV epidemic.
   1. Collect, analyze, and compare current service models in use among RWCA-funded service providers.
      a. Assess impact of current changes in HIV disease in relation to service delivery.
      b. Identify population characteristics of clients that are dependent on the "broker" model to access services and compare with those that are not.
      c. Identify and evaluate alternate client service models (such as peer advocacy, strengths-based case management, and acuity-based models) that address current changes in HIV disease.
      d. Obtain input on client service models from the RW Subcommittee of the Virginia HCPC.
      e. Obtain Peer Review Committee input on client service models.
   2. Disseminate findings in items D.1 to all Title II consortia and providers, other RWCA-funded planning bodies and providers, and other interested stakeholders.
   3. Revise client service guidelines based on findings.
   4. Implement new guidelines in following year's service contracts.

E. Strengthen provider competence and proficiency to meet clients' HIV-related health and service needs
   1. Ensure provision of care consistent with USPHS guidelines
      a. AETC and VHARCC will include assessment of provider learning needs related to clinical provision of care consistent with USPHS guidelines in overall statewide assessment of provider learning needs.
      b. AETC and VHARCC will report findings to VDH and develop statewide training plan to address identified clinical learning needs.

c. The Statewide Independent Peer Review Team will monitor compliance with guidelines during site visits.
d. AETC and VHARCC will provide consultation and technical assistance for providers to address related clinical issues as they occur.

2. Ensure provision of case management consistent with VDH standards
   a. AETC and VHARCC will include assessment of provider learning needs related to provision of case management consistent with VDH standards in overall statewide assessment of provider learning needs.
   b. AETC and VHARCC will report findings to VDH and develop statewide training plan to address identified learning needs.
   c. The Statewide Independent Peer Review Team will monitor compliance with case management standards during site visits.
   d. AETC and VHARCC will provide consultation and technical assistance for providers to address related issues as they occur.
3. Empower new & small agencies through capacity building
   a. VDH will obtain clarified definition from HRSA on allowable uses of capacity building funds
   b. VDH will develop a statewide policy for use of capacity building funds.
   c. Each RWCA Title II regional consortium will select one agency in their region that would most benefit from capacity building funds
   d. Dependent upon HRSA and VDH approval, each selected agency will receive capacity building funds as a pilot program
   e. VDH will evaluate effectiveness of pilot program and decide whether to continue/expand.

F. Enhance clients' ability to navigate the service system effectively
1. Collect, analyze, and compare current informational needs of clients.
   a. Assess role of information and referral system to meet providers and consumers' service information needs.
   b. Obtain input from the RW Subcommittee of the Virginia HCPC, the SCP Advisory Committee, and all Consortia.
2. Develop method to update inventory lists.
   a. Contact all listed agencies to verify and update information.
   b. Distribute to lead agencies & Consortia for review.
3. Develop user-friendly resource guide for the VDH website.
   a. Ensure variables such as distance from client, specialties, language capabilities, etc. are included
   b. Develop interactive map graphic linked to the database.

Goal I. Provide equitable access to services for all PLWH/As – regardless of age, race, ethnicity, gender, sexual orientation, religion, socioeconomic status, residence, language and physical appearance.

Objective	Year 1	Year 2	Year 3
Assess current level of access to services for special populations	Identify potential data sources for HIV-related service information and in-care indicators. Increase data sharing between identified data sources through establishing formalized agreements with all identified agencies. Examine and evaluate methodologies increasing utilization of alternate (cumulative) data sources to increase accuracy of Unmet Need Estimate. Assess levels of access to service for special populations.		
Increase and strengthen opportunities for direct client feedback on access and barriers to services	Obtain Peer Review Committee input on mechanisms to obtain direct client input on service barriers and access issues.	Collect, analyze, and compare current client satisfaction surveys in use among Title II-funded service providers. Identify and evaluate components of surveys addressing access to services.	Disseminate findings to all Title II consortia and providers, other RWCA-funded planning bodies and providers, local performance sites of the AETC, the VHARCC and other interested stakeholders.

		Present findings to the RW Subcommittee of the Virginia HCPC.	
Empower clients by equipping them with knowledge about their service-related rights and responsibilities as well as avenues for recourse to effectively address service access barriers and issues			Collect, analyze, and compare current rights and responsibilities statements/policies in use among statewide HIV service providers. Assess the current role of client/peer advocates and related service providers in educating clients on service-related rights, responsibilities, and recourses. Develop client brochure for statewide use addressing HIV service-related rights, responsibilities, and recourse related to service access and equitable treatment. Add related informational resources and links to VDH website, including links to regional grievance procedure information, legal resources, and advocacy groups.
Increase collaboration between HIV service providers and local special interest groups			Assess outreach by consortia and planning councils to non-participating agencies

representing potentially underserved populations			Increase recruitment of previously untapped special interest groups (such as minority or ethnicity-based community groups, faith-based organizations, and special population advocacy groups) Assess and compile information on capacity building trainings, technical assistance and support available to these groups.
Address language barriers to improve access to services for non-English speaking clients.		Assess current translation needs Develop agency-specific system plans Increase recruitment of multilingual providers	
Enhance provider skills abilities and effectiveness in working with diverse and under-served populations in order to reduce barriers to services.	AETC and VHARCC will include assessment of provider learning needs related to cultural competence and serving diverse and under-served populations in overall statewide assessment of provider learning needs. Refer findings of learning needs assessment to Peer Review Committee for recommendations on including this in standards. AETC and VHARCC will report findings to VDH and develop statewide training plan to address identified needs related to improving cultural competency and ability to effectively address issues related to sexual diversity. AETC and VHARCC will provide consultation and technical assistance for providers to address related client issues as they occur.		

Goal II. Increase collaboration between care and prevention to increase healthy behaviors among HIV-positive individuals and reduce the transmission rate of new HIV infections.

Objective	Year 1	Year 2	Year 3
Increase the number of HIV-positive individuals being referred to care / treatment.	Assess linkage of HIV-positive individuals into care. Based on results from assessment, identify gaps in services and other factors hampering linkage of HIV-positive individuals into care	Examine and evaluate strategies to improve linkage of newly-diagnosed and out-of-care individuals into primary medical services	Determine if linkages were successful by measuring number of newly-diagnosed referred to care.
Increase utilization and awareness of prevention for positives services to promote ownership and responsibility for HIV-positive individuals.	VDH Community Services Unit will survey prevention providers to determine capacity of prevention case managers, peer educators, and adherence counselors	VDH & SERL will conduct data analysis to measure utilization of prevention for positives services RW Subcommittee of the HCPC will develop client survey to measure awareness of prevention for positives services	If there is available capacity, VDH Community Services Unit will instruct prevention for positives providers to increase advertisement of their services VDH HIV Prevention Community Planner will provide updates on prevention for positives services at RWCA Title II Quarterly Contractors' Meetings
Increase the number of care providers offering prevention messages to those that are HIV-positive.	The RW Subcommittee of the Virginia HCPC will assess current practices among care providers.	The RW Subcommittee will present findings to VDH and the Peer Review Committee. The Peer Review Committee will define what should be contained in a prevention message	VDH will include updated requirement and definition in contracts with care providers. Local performance sites of the AETC will provide training for care providers on appropriate methods of delivering prevention messages and addressing

			substance abuse issues. Local performance sites of the AETC will provide technical assistance to care providers.

Goal III. Ensure that HIV-positive individuals receive optimum health care and support services that extend and improve quality of life.

Objective	Year 1	Year 2	Year 3
Ensure access to primary medical care within two weeks of initial contact with the care system	Collect, analyze, and compare current waiting times for clients to access primary medical care Examine methods to minimize waiting times for access to services		
Ensure uninterrupted access to antiretroviral medications	Collect, analyze, and compare data on current client access to antiretroviral medications. Examine methods to ensure access		
Increase knowledge of community services not funded by RWCA.	VDH will investigate use of statewide information and referral program. Consortia will start survey of non-funded services including eligibility and application requirements.	Consortia will include goal in applications addressing increased use of non-funded programs for support services. Each Consortium will recruit one new non-funded provider as a member.	At least 3 regions will include information on non-funded providers in their informational materials for clients, including Consortia web sites. Each Consortium will recruit a second new non-funded provider as a member.
Increase number of clients using non RWCA-funded programs for support services	VDH will add fields to VACRS to capture information on use of non-funded providers.	Consortia will include information in monthly report or in VACRS on use of non-funded providers. VDH will develop policy on referring to non-RWCA funded providers before utilizing RW funds for support services.	RWCA providers will refer clients to non-funded providers for support services before using RWCA funds.
Assess response of case management to a	Collect, analyze, and compare current service models in use		

shifting HIV epidemic	among RWCA-funded service providers. Disseminate findings to all Title II consortia and providers, other RWCA-funded planning bodies and providers, and other interested stakeholders. Revise client service guidelines based on findings. Implement new guidelines in following year's service contracts.		
Strengthen provider competence and proficiency to meet clients' HIV-related health and service needs		Ensure provision of care consistent with USPHS guidelines Ensure provision of case management consistent with VDH standards Empower new & small agencies through capacity building	
Enhance clients' ability to navigate the service system effectively	Collect, analyze, and compare current informational needs of clients. Develop method to update inventory lists. Develop user-friendly resource guide for the VDH website.		

Section 4. How will we monitor our progress: How will we evaluate our progress in meeting our short and long-term goals?

Implementation, Monitoring and Evaluation Plans

Various strategies are employed in the Commonwealth of Virginia to improve quality of care and monitor progress in meeting long- and short-term goals and objectives. These include the following initiatives which are described below: 1) Quality Management and Training; 2) Contract Monitoring Process; and 3) Community Feedback.

I. Quality Management and Training

Virginia's quality management program emphasizes the importance of establishing and implementing protocols and policies to ensure that each PLWH/A has access to a quality of medical care and support services consistent with appropriate standards and guidelines. The multidisciplinary Statewide Independent Peer Review Team is used to evaluate providers' quality of care and adherence to federal and state standards. Training needs identified are referred to the Pennsylvania/MidAtlantic AETC or to the VHARCC for follow up.

The quality management review performed by the Statewide Independent Peer Review Team during the site visit includes a review of the provider's quality management plan. Technical assistance is offered to enhance the provider's plan as needed. In addition, each consortium is required by contract to develop and implement a regional quality assurance plan with measurable outcome objectives. Compliance with this contractual requirement is documented in the annual lead agency site visit conducted by the VDH contract monitors.

The Statewide Independent Peer Review Team performs site visits to all consortia subcontractors on a two-year cycle. The team consists of subject matter experts that include nurse practitioners, social workers, consumers, a dentist, and lead agency representatives. The areas reviewed are the core services and the support services. The makeup of the team is tailored to the services provided by the agency being reviewed. Since its inception four years ago, the team has developed a broader base, enabling it to offer technical assistance at the time of the peer review site visit. This allows site visits to serve the dual purpose of identifying problems and coaching providers toward solutions. Site visits include a pre-conference where the Statewide Independent Peer Review Team members meet with the provider staff in order to familiarize them with the peer review process. Then each team member performs an assessment of the specific services to which his or her expertise is relevant. For example, the social worker reviews case management services. The dentist reviews oral health services, etc. A trained Statewide Independent Peer Review Team member who is a PLWH/A conducts the client interviews. Services are reviewed both programmatically and at the direct service level through client record reviews using standardized modules that were revised during the

current grant year. The modules include key indicators that evaluate compliance with service requirements (such as documenting eligibility) and adherence to established clinical guidelines (such as monitoring CD4 counts and viral loads at appropriate intervals). Administrative aspects of service delivery are evaluated by the lead agency representative. When the evaluations are complete, the team confers and then presents its findings to the provider staff in a post-conference. The team leader summarizes the results of the visit in a written report that is reviewed by the VDH Quality Management Nurse and then provided to the lead agency. Deficiencies require a response from the service provider in the form of a corrective action plan. VDH and the lead agency will then assist the provider in correcting their deficiencies.

A. Peer Review Committee

The VDH Quality Management Nurse coordinates the peer review process and chairs a Peer Review Committee. The committee includes Statewide Independent Peer Review Team members and consortia lead agency representatives. The committee reviews, revises, and establishes state standards that serve as the basis for assessing quality of services during the site visits performed by the team. In addition, the committee develops tools used during site visits to review records, evaluate services and determine client satisfaction with services received. In the coming year the committee will expand data collection to include trends and to quantify the deficiencies in specific areas. Primary areas to be addressed are:

- The percentage of clients receiving any antiretroviral treatment,
- Of clients receiving antiretroviral therapy, the percentage of treated clients receiving optimal regimens consistent with USPHS guidelines,
- Of clients who should be receiving antiretroviral therapy, the percentage receiving suboptimal or no antiretroviral therapy with reason for lack of or suboptimal therapy,
- The percentage of clients receiving tuberculosis tests (PPDs) within 4 weeks of initial medical assessment and annual re-screening,
- The percentage of clients referred for and/or receiving appropriate dental care, and
- The percentage of clients receiving case management without documented case management needs.

The Peer Review Committee will play a key role in implementing and monitoring all three long-term goals in the SCP. As outlined in Section 3, the Peer Review Committee will be utilized to increase and strengthen opportunities for direct client feedback on access and barriers to services by providing input on mechanisms to obtain direct client input on service barriers and access issues. Also, the committee will help enhance provider skills, abilities and effectiveness in working with diverse and under-served populations in order to reduce barriers to services by providing recommendations on including provider learning needs in the Peer Review Standards. To help increase the number of care providers

offering prevention messages to those that are HIV-positive, the Peer Review Committee will define what should be contained in a prevention message. Also, the Peer Review Committee will provide input on current client service models to assess the response of case management to a shifting HIV epidemic. Finally, the Peer Review Committee will monitor and evaluate its progress in implementing these SCP goals.

B. ADAP Advisory Committee

The VDH ADAP quality management program assesses medication treatment regimens to determine if the prescribed regimen is consistent with the current USPHS guidelines for the treatment of HIV and opportunistic infections. The ADAP Advisory Committee is the main planning body involved in ADAP quality management efforts. The committee is comprised of physicians, a nurse practitioner, a pharmacist, and consumers. Members play a key role in acting as liaisons from the community to VDH staff. Committee members have contributed by identifying needs that ADAP must address, including gaps in medication access and challenges to the medication distribution system. Outcomes of quality management activities are reported to the ADAP Advisory Committee. The ADAP Coordinator oversees quality management for ADAP by conducting chart reviews to determine health department compliance with established guidelines for the program and assessment of medication treatment regimens. The ADAP Coordinator will also review charts to monitor the SCP goal of ensuring uninterrupted access to antiretroviral medications. During visits, the ADAP Coordinator provides training and technical assistance to address the needs of the local health department staff.

The ADAP Advisory Committee will play an important role in implementing the long-term goal in the SCP of ensuring that HIV-positive individuals receive optimum health care and support services that extend and improve quality of life. As outlined in Section 3, the ADAP Advisory Committee will be utilized to ensure uninterrupted access to antiretroviral medications by encourage providers to make cost-effective choices when prescribing.

C. AIDS Education and Training Center (AETC) and HIV/AIDS Resource and Consultation Center (VHARCC)

The two Virginia local performance sites of the Pennsylvania/ MidAtlantic AETC provide clinical training and technical assistance to medical clinicians in Virginia. VHARCC provides training support to health care providers at all levels, focusing on case management providers, local AIDS service organizations, community-based organizations, public safety agencies, and corrections facilities. Established by the Virginia General Assembly to help health care providers in their efforts to serve persons infected and affected by HIV/AIDS, VHARCC provides a broad range of educational opportunities and training and referrals to other services. In addition to the main center at VCU in Richmond, and there are

four regional satellite sites across Virginia: Norfolk, Roanoke, Harrisonburg, and Springfield.

The mission statements and roles of the AETC and VHARCC are very similar, although their primary target audiences are somewhat varied. VHARCC's emphasis is on case managers, social workers, mental health providers and providers not covered by other funding sources; the AETC focuses primarily on clinical care providers including physicians, nurse practitioners and physicians' assistants. The AETC and VHARCC often work collaboratively to maximize the specialties and resources of each by improving provider skills, abilities, and effectiveness in working with diverse and under-served populations. In addition, efforts are being made to increase the number of community providers who are able to offer prevention messages and basic care to infected persons. Standardized evaluations will be conducted for all programs and trainings administered by both the AETC and VHARCC.

II. Contract Monitoring Process

To help monitor contracts and ensure compliance with federal regulations, VDH has two Title II contract monitors. They work closely with each contractor, reviewing and responding to programmatic reports and tracking expenditures by monitoring and approving invoices on a monthly basis. The contract monitoring process is documented through contract files which include a copy of the contract, all contract renewals and modifications, program reports and site visit reports. The contract monitors will also check to ensure that the number of providers is sufficient to meet the SCP goal of ensuring access to primary medical care within two weeks of initial contact with the care system.

All contractors are required to submit monthly reports to VDH. The reports detail progress towards objectives in the work plans. Additionally, each contractor submits monthly invoices with detailed information on line item expenditures. The contract monitors review the reports and invoice documentation. Once all documentation is approved, invoices are submitted to fiscal staff for payment.

All contractors receive an annual site visit performed by the contract monitors. These visits include a review of fiscal records and verification of personnel expenditures through review of time and effort reports. Administrative mechanisms and oversight of subcontractors are also reviewed. If deficiencies are found, the contractor must submit a plan for correction. This plan is reviewed by the contract monitor and once approved, progress towards completion and correction of deficiencies is monitored. If deficiencies are numerous or very serious, follow-up visits are conducted. Additionally, all contractors are required to perform annual visits to each subcontractor.

In addition to their regular responsibilities that help ensure that HIV-positive individuals receive optimum health care and support services that extend and improve

quality of life, the VDH contract monitors will also play an important role in increasing collaboration between care and prevention. To increase the number of care providers offering prevention messages to those that are HIV-positive, the contract monitors will ensure that an updated prevention message requirement and definition is included in contracts with care providers.

III. Community Feedback

In order to ensure the community that the needs and goals addressed in the SCSN and SCP are implemented, there needs to be increased communication from VDH. Currently, the Virginia HCPC is the most established connection between VDH and the HIV community. Although the main mission of the HCPC is focused on prevention strategies, the RW Subcommittee of the HCPC advises VDH on assessment of client care needs, development of services to meet those needs, and evaluation of care outcomes. As outlined in the previous section, the RW Subcommittee will be utilized to help implement objectives focused on increasing collaboration between care and prevention to increase healthy behaviors among HIV-positive individuals and reduce the transmission rate of new HIV infections.

In addition to the HCPC, the SCSN Steering Committee and SCP Advisory Committee have also connected VDH with the HIV community. Plans are currently being developed for these groups to help monitor and evaluate progress in meeting the short and long term goals contained in the SCP. Twice yearly, meetings with combined members of the SCSN Steering Committee and SCP Advisory Committee will be held to evaluate the progress of VDH in implementing its goals. Also, with the prospect of significant structural and funding changes with the impending reauthorization of the RWCA, the combined committee will assist VDH in redefining the short and long term goals as necessary.

Appendix A:

List of Acronyms

List of Acronyms

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASO	AIDS Service Organization
ATS	Anonymous HIV Counseling and Testing Site
AZT	Azidothymidine or Zidovudine
CANDII	Children's AIDS Network Designed for Interfaith Involvement
CD4	Cluster of Differentiation Antigen 4, the primary binding receptor on T-cells for HIV
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHRI	Community Health Research Initiative
DHCD	Department of Housing and Community Development
DMAS	Department of Medical Assistance Services
DMHMRSAS	Department of Mental Health, Mental Retardation, and Substance Abuse Services
DOC	Department of Corrections
EMA	Eligible Metropolitan Area
FPL	Federal Poverty Level
HAART	Highly Active Antiretroviral Therapy
HARS	HIV/AIDS Reporting System
HCPC	HIV Community Planning Committee
HIPP	Health Insurance Premium Payment Program
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People With AIDS
HRSA	Health Resources and Services Administration
IDU	Injection Drug Users
LHD	Local Health Department
LIS	Low Income Subsidy

MAI	Minority AIDS Initiative
MHC	Migrant Health Center
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSM	Men Who Have Sex with Men
PCRS	Partner Counseling and Referral Service
PLWH/A	Persons Living With HIV/AIDS
PLWHnA	Persons Living With HIV not AIDS
RWCA	Ryan White Comprehensive AIDS Resources Emergency Act
SCP	Statewide Comprehensive Plan
SCSN	Statewide Coordinated Statement of Need
SPAP	State Pharmaceutical Assistance Program
USPHS	United States Public Health Service
UVA	University of Virginia
V.A.	Department of Veterans Affairs
VACRS	Virginia Client Reporting System
VCU	Virginia Commonwealth University
VCUHS	Virginia Commonwealth University Health System
VCU-SERL	Virginia Commonwealth University Survey and Evaluation Research Laboratory
VDH	Virginia Department of Health
VHARCC	Virginia HIV/AIDS Resource and Consultation Center

Appendix B:

2003 Epidemiology Profile: HIV and AIDS in Virginia

To view this report, please visit the following website:
http://www.vdh.virginia.gov/std/DataStats/EpiProfile/EPI%20Profile%20022105.pdf

Appendix C:

Statewide HIV/AIDS Resource and Referral Listings

To view this document, please visit the following website:
http://www.vdh.virginia.gov/std/hotline/RR%20November%202005.pdf